Law Reform Commission

Substitute Consent to Health Care

2004

Manitoba
Law Reform
Commission

Manitoba

Law Reform Commission

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TABLE OF CONTENTS

		Page #
CHAPTER 1 - INTRODUCTION		1
A.	BACKGROUND	1
B.	ACKNOWLEDGMENTS	4
CHAPTER 2 - CONSENT TO MEDICAL TREATMENT		5
A.	THE COMMON LAW OF CONSENT	5
B.	EXCEPTION FOR EMERGENCIES	6
C.	PRESUMPTION OF COMPETENCE	7
D.	CONSENT BY OR FOR MINORS	7
E.	CONSTITUTIONAL PROTECTION	8
F.	SUBSTITUTE CONSENT AT COMMON LAW	9
CHAPTER 3 - SUBSTITUTE CONSENT LEGISLATION		10
A.	INTRODUCTION	10
1.	Manitoba	10
2.	Legislation in Other Canadian Jurisdictions	12
(a)	Ontario	13
(b)	British Columbia	13
(c)	Prince Edward Island	14
(d)	Yukon Territory	14
(e)	Québec	15
(f)	Alberta	15
(g)	Saskatchewan	15
(h)	Newfoundland	16
(I)	Nova Scotia	16
(j)	Other Canadian Jurisdictions	16
(k)	Legislation in the United States	17
(l)	Legislation in the United Kingdom	18
CHAPTER 4 - DISCUSSION		19
A.	NEED FOR REFORM	19
B.	OPTIONS FOR REFORM	20
C.	ENACTMENT BY AMENDMENT	21
D.	FEATURES OF THE PROPOSED LEGISLATION	21
1.	Codification of the Common Law of Consent	21
2.	Capacity to Consent	23
3.	Hierarchy of Substitute Decisions Makers	27
4.	Qualifications of Substitute Decisions Makers	32
5.	Resolution of Disputes Among Substitute Decision Makers	35

6. Scope of Authority of Substitute Decision Makers 39
7. Guidelines for Substitute Decision Makers 42
8. Access to Information 47
9. Review and Appeal Process 48
10. Protection from Liability 49
11. Additional Matters 50

CHAPTER 5 - LIST OF RECOMMENDATIONS 51

EXECUTIVE SUMMARY 55

RÉSUMÉ 59

CHAPTER 1

INTRODUCTION

A. BACKGROUND

At common law (codified by statute in some provinces), every person has the right to consent to, or to refuse, medical treatment. If a person is unable to give consent or refuse, then the following "substitutes" may authorize or refuse the treatment on their behalf:

- a statutorily authorized substitute (proxy, committee, public trustee, etc.);[1]
- a doctor under the emergency doctrine; or
- the court under its *parens patriae* jurisdiction.[2]

Apart from the above options, the common law does not permit *anyone* to give (or refuse) consent to medical treatment on behalf of a person who is unable to give such consent him- or herself.

In Manitoba, a competent person over the age of 16 may appoint another person as a proxy to make health care decisions on their behalf in the event that they become unable to make such decisions.[3] Unfortunately, it appears that many people may not take advantage of this option,[4] for whatever reason. Given this state of the law, it will often happen that no one but the court (or perhaps the Public Trustee under *The Mental Health Act*)[5] will have legal authority to consent to medical treatment for a person who does not have the capacity to do so him- or herself (except parents or guardians in the case of immature minors). This fact raises serious concerns relating to the autonomy, security and bodily integrity of individuals (patients) as well as the professional integrity and liability of professionals.

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[1] In Manitoba, legislation authorizing a substitute decision maker includes: *The Health Care Directives Act*, C.C.S.M., c. H27.; *The Mental Health Act*, C.C.S.M. c. M110; *The Public Trustee Act*, C.C.S.M., c. P275; and *The Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90.

[2] Literally translated means "parent of the country", and refers to the traditional role of the Crown as guardian of persons under a legal disability, including children, mentally incompetent adults, and any person who, for any reason, is unable to act on his or her own behalf. This power is now vested in the Manitoba Court of Queen's Bench and has been described by the Supreme Court of Canada as being limited only by the best interest of the person in need of protection: *Re Eve*, [1986] 2 S.C.R. 388, (1986), 31 D.L.R. (4th) 1.

[3] *The Health Care Directives Act*, C.C.S.M. c. H27.

[4] See *e.g.*, Alberta Law Reform Institute and Health Law Institute, *Advance Directives and Substitute Decision-Making in Personal Healthcare* (Report #64, 1993) 8, and B. Sneiderman, "Patients' Advance (Health Care) Directives" in B. Sneiderman, J. Irvine and P. Osborne, eds., *Canadian Medical Law* (3rd ed., 2003) 599 at 633-634.

[5] *The Mental Health Act*, C.C.S.M. c. M110, Part 9.

The Commission recognized the need for study of this issue in its 1991 Report on *Self-Determination in Health Care (Living Wills and Health Care Proxies)*,[6] but did not deal with it in that report due to the already broad scope of inquiry required by the main subject matter. Following the release of the report, the chair of the Health Sciences Centre Consent Committee expressed the Committee's concern over a "very large uncertainty with respect to ... basic related issues" and, in particular, the absence of statutorily authorized substitute decision makers.[7]

Because of this gap in the law, the medical profession has developed a practice of consulting with family members, according to the priorities set out in *The Human Tissue Act*[8] or *The Mental Health Act*.[9] This practice does not carry legal authority and may result in conflict, confusion and potential liability for health care practitioners.[10] On the other hand, Professor Philip Osborne suggests that the courts may, in fact, find the practice acceptable, and that it is advisable in any event:

> Canadian courts have yet to consider the legal status of an in-family substituted consent for an incompetent patient. However, it is likely that such consent would meet with approval, given that the principle has found endorsement in provincial legislation such as the *Health Care Consent Act* (Ontario). In any event, it is sound practice to seek a treatment consensus amongst the next of kin of incompetent patients, if only to obviate a law suit by a disgruntled family member. It is, of course, axiomatic that the physician ensure that the next of kin are seeking to protect the patient's interest because not all families are willing or able to do so.[11]

Typically, the hierarchy within which health care providers will seek consent from family members is the following:

- spouse
- child
- parent
- sibling

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[6] Manitoba Law Reform Commission (hereinafter referenced as MLRC), *Self-Determination in Health Care (Living Wills and Health Care Proxies)* (Report #74, 1991) 1, n. 1.

[7] Letter from D.B. Craig, M.D., to the Commission (12 November 1991). Dr. Craig's letter also raised the issue of the right of minors to consent to health care which prompted the Commission's Report on *Minors' Consent to Health Care* (Report #91, 1995).

[8] *The Human Tissue Act*, C.C.S.M. c. H180, s. 3(1.1).

[9] *The Mental Health Act*, C.C.S.M. c. M110, s. 28.

[10] *Re T*, [1992] 4 All E.R. 649 at 653 (C.A.) and *Re S* (1993), 49 E.T.R. 307 (Nfld. T.D.), cited in E.I. Picard and G.B. Robertson, *Legal Liability of Doctors and Hospitals in Canada* (3rd ed., 1996) 64; B.M. Dickens, "The Role of Family in Surrogate Medical Consent" (1980) 1 Health L. Can. 49; K. Evans, "The Law of Consent" (1990) 10 Health L. Can. 227; K. Evans, "Mental Competence, Treatment and Sub Consent: A Lawyer's Perspective" (1988) 8 Health L. Can. 96.

[11] P. Osborne, Consent to Treatment" in B. Sneiderman, J. Irvine and P. Osborne, eds., *Canadian Medical Law* (3rd ed., 2003) 19 at 32.

The fact that there is no legal sanction for this widespread practice creates numerous troubling problems for health care providers. What are they to do when, for example, the highest ranking substitute is unable or unwilling to make a decision, or to make a decision that is either (a) consistent with the patient's known wishes, or (b) in the patient's best interests? What if there is a person who holds a lower rank in the hierarchy than the substitute (or is completely outside it) who appears to have the most complete and current understanding of the patient's wishes? If the highest ranking substitute is a sibling, what if there is more than one sibling and the siblings disagree on the decision to be made? What if there is a conflict between the patient's own wishes, which have not been written down, in accordance with *The Health Care Directives Act*, and what the health care provider considers to be the patient's best interests?

The Commission has issued a number of reports that have touched on, or are relevant to, the issue of substitute health care decision making. Our report on *Self-Determination in Health Care (Living Wills and Health Care Proxies)*[12] concerned the ability of individuals to ensure that their wishes were respected even after they were no longer competent to make such decisions. Our report on *Emergency Apprehension, Admissions and Rights of Patients under The Mental Health Act*[13] considered the rights of individuals who were adjudged to be mentally incompetent, including their right to consent to, or refuse, treatment. Similarly, our report on *Minors' Consent to Health Care*[14] considered the ability of minors to consent to or refuse medical treatment. The Commission's reports on *The Human Tissue Act*[15] and *Sterilization and Legal Incompetence*[16] considered the issues of consent and substitute consent in the context of specific medical procedures. In 1999, our report on *Informal Assessment of Competence*[17] dealt with the methods by which an individual's capacity to consent can be assessed. Finally, our report on *Adult Protection and Elder Abuse*[18] touched on some of the methods by which substitute decision makers may be appointed for certain vulnerable individuals.

The issue of substitute consent to health care again figured prominently in the Commission's consideration of issues related to the withdrawing and withholding of life sustaining treatment.[19] Many respondents to our discussion paper suggested that the resolution of the issue of substitute consent was either more pressing than, or a necessary pre-condition to, addressing the issue of end-

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[12] MLRC, *Self-Determination in Health Care (Living Wills and Health Care Proxies)*, *supra* n. 6.

[13] MLRC, *Emergency Apprehension, Admissions and Rights of Patients under The Mental Health Act* (Report #29, 1979).

[14] MLRC, *Minors' Consent to Health Care* (Report #91, 1995).

[15] MLRC, *The Human Tissues Act* (Report #66, 1986).

[16] MLRC, *Sterilization and Legal Incompetence* (Report #76, 1992).

[17] MLRC, *Informal Assessment of Competence* (Report #102, 1999).

[18] MLRC, *Adult Protection and Elder Abuse* (Report #103, 1999).

[19] MLRC, *Withholding or Withdrawing Life Sustaining Medical Treatment* (Discussion Paper, 2002).

of-life decision making, because most disputes related to withdrawing or withholding treatment involved an incapable patient. Accordingly, the Commission has undertaken this study of the issue to follow shortly on the publication of our final report on *Withholding or Withdrawing Life Sustaining Medical Treatment*,[20] and the two Reports should be considered complementary.

Because the Commission has touched so broadly on related issues in the past, this report will focus on two specific issues: namely, the codification of the common law of consent to medical procedures and substitute consent to medical procedures in circumstances that existing legislation does not address. Although related issues may be referred to occasionally, they will not be discussed in detail.

In particular, because Manitoba has already enacted legislation relating to substitute decision making with respect to persons with mental disorders,[21] persons with a mental disability,[22] and persons who have executed a health care directive,[23] and with respect to the donation of body parts before or after death,[24] and because the Commission recommended against legislating the "mature minor" rule in our 1995 report,[25] this report will not address those categories of substitute decision making, except to the extent that they are relevant to the issue of substitute decision making on behalf of *other* persons, and in the context of considering whether it would be appropriate to introduce a single, comprehensive set of rules related to substitute decision making.

B. ACKNOWLEDGMENTS

We wish to thank Jonathan G. Penner, an independent research consultant, who assisted us in researching the law in this area and in preparing the Report for the Commission's consideration. We also thank Blane Morgan who collaborated with Mr. Penner on the project. The members are also grateful to Prof. Philip Osborne of the Faculty of Law, University of Manitoba, who provided his comments during the Commission's deliberations of the options for reform.

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[20]MLRC, *Withholding or Withdrawing Life-Sustaining Treatment* (Report #109, 2003).

[21]*The Mental Health Act*, C.C.S.M. c. M110.

[22]*The Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90.

[23]*The Health Care Directives Act*, C.C.S.M. c. H27.

[24]*The Human Tissue Act*, C.C.S.M. c. H180.

[25]MLRC, *Minors' Consent to Health Care*, *supra* n. 14 at 34.

CHAPTER 2

CONSENT TO MEDICAL TREATMENT

A. THE COMMON LAW OF CONSENT

The Euro-Canadian culture places a high value on individual liberty, personal security and bodily integrity. Accordingly, the common law gives a "high degree of protection" to an individual's personal security and bodily integrity. It is a basic principle of the common law that every person has the right to be free from unwanted interference or touching, including medical treatment.

> ... It should not be forgotten that every patient has a right to bodily integrity. This encompasses the right to determine what medical procedures will be accepted and the extent to which they will be accepted. Everyone has the right to decide what is to be done to one's own body. This includes the right to be free from medical treatment to which the individual does not consent. This concept of individual autonomy is fundamental to the common law.....[1]

Any interference with the body is a battery and so important is the right to be free from interference that a breach of the right is actionable *per se*; in other words, damages may be awarded for battery without proof of harm or loss.[2] This is substantially different from other actions for damages based on tort (negligence, defamation, and the like) where a claimant must prove that he or she has suffered actual damage or loss.

In fact, that freedom from unwanted interference is constitutionally protected under section 7 of the *Canadian Charter of Rights and Freedoms*, which guarantees the right to life, liberty and security of the person:

> ... The common law right to bodily integrity and personal autonomy is so entrenched in the traditions of our law as to be ranked as fundamental and deserving of the highest order of protection. This right forms an essential part of an individual's security of the person and must be included in the liberty interests protected by s. 7. Indeed, in my view, the common law right to determine what shall be done with one's own body and the constitutional right to security of the person, both of which are founded on the belief in the dignity and autonomy of each individual, can be treated as coextensive.[3]

As noted above, the right to freedom from bodily interference includes the right to consent

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[1] *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119, (1993), 100 D.L.R. (4th) 609 at 618.

[2] MLRC, *Minors' Consent to Health Care* (Report #91, 1995) 2.

[3] *Fleming v. Reid* (1991), 82 D.L.R. (4th) 298 at 312 (Ont. C.A.), per Robins, J.A.

to, or refuse, medical treatment. At common law, each person has the right to accept or to refuse treatment, and no one may administer treatment to a person contrary to the person's wish, even where it may be necessary to preserve their life or health.[4]

It should be noted that the corollary of this right, that being a right to compel or require medical treatment, has not been accepted to date in Canadian law, which point was the subject of some attention in our discussion paper on *Withdrawing and Withholding Life-Sustaining Treatment*.[5] Thus the right to consent to medical treatment may be characterized as a negative right, that which *prevents* another from doing something, rather than a positive right, being that which *requires* someone to do something.

At common law there are four pre-requisites to a valid consent:

- it must be voluntary;
- the patient must have legal and mental capacity;
- it must be specific to both the treatment and the person administering it; and
- it must be informed, in that the patient must understand the nature of the procedure, the benefits, the risks, and any alternative treatments.[6]

B. EXCEPTION FOR EMERGENCIES

The common law does permit medical treatment without the patient's consent in "emergency" situations. When a person is unable to give consent (due to, for example, unconsciousness or impairment), but immediate medical treatment to preserve their life or health is required, and there is no person (such as a family member) who can indicate what the person would want in the situation or any other indication of what their wishes would be, health care providers can assume that the person would consent to emergency treatment to save their life or preserve their health, and may administer treatment required to do so.

> ... The delivery of medical services is rendered in such circumstances either on the rationale that the doctor has implied consent from the patient to give emergency aid or, more accurately in my view, on the rationale that the doctor is privileged by reason of necessity in giving the aid and is not to be held liable for so doing. On either basis, in an emergency the law sets aside the requirement of consent on the assumption that the patient, as a reasonable person, would want emergency aid to be rendered if she were capable of giving

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[4] *Reibl* v. *Hughes*, [1980] 2 S.C.R. 880, (1980), 114 D.L.R. (3d) 1 (consent generally); *Nancy B.* v. *Hôtel Dieu de Québec* (1992), 86 D.L.R. (4th) 385 (Qué. S.C.) (right to refuse medical treatment); *Malette* v. *Shulman* (1991), 67 D.L.R. (4th) 321 (Ont. C.A.) (physician's obligation to respect patient's wishes even in emergency).

[5] MLRC, *Withholding or Withdrawing Life-Sustaining Treatment* (Discussion Paper, 2002).

[6] B. Grainger, E. Margolese and E. Partington, "Legal and ethical consideration in blood transfusion" (1997), 156 C.M.A.J. (11th Supp.) S50 at S50-S51.

instructions."

The emergency exception, however, does not apply in situations where the health care provider is aware that the person expressed a wish, while capable, not to receive such treatment – for example, where a Jehovah's Witness carries a card indicating that she does not wish to receive a blood transfusion.[8]

C. PRESUMPTION OF COMPETENCE

At common law, every adult person is presumed to be competent to give or refuse consent to medical treatment in general.[9] In Manitoba, this presumption has been codified by legislation and expanded to include young people once they have turned 16.[10] Despite this presumption, health care providers are required to ensure that a patient has the mental capacity to make the *specific* decision required *at that moment*. Patients can be competent in general but lack capacity to make the specific decision required (for example, a patient who has been rendered unconscious in an accident), or a patient may be incompetent in general but have capacity to make the specific decision required.[11]

D. CONSENT BY OR FOR MINORS

In Manitoba, the "age of majority", being the age at which a person officially becomes an "adult", is 18.[12] Upon attaining the age of majority, a person has full "legal" capacity and can make all decisions, including health care decisions, for him- or herself. The law grants a young person who is at least 16 years of age some limited legal capacity: to enter into employment contracts;[13] to

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[7] *Malette* v. *Shulman*, *supra* n. 4, at 328-329, per Robins, J.A.

[8] *Id.*

[9] *Khan* v. *St. Thomas Psychiatric Hospital* (1992), 87 D.L.R. (4th) 289 at (Ont. C.A.), leave to appeal to S.C.C. ref'd (1992), 93 D.L.R. (4th) vii.

[10] *The Mental Health Act*, C.C.S.M. c. M110, s. 2; *The Health Care Directives Act*, C.C.S.M. c. H27, s. 4(2).

[11] The Commission notes that, although there is in theory a distinction between general "competence" and the specific "capacity" relevant to a particular decision, this distinction is not generally observed in the literature. We therefore use the two terms interchangeably in this Report.

[12] *The Age of Majority Act*, C.C.S.M. c. A7, s. 1.

[13] *The Employment Standards Code*, C.C.S.M. c. E110, s. 84.

drive a car;[14] and to join the armed forces;[15] and, by virtue of *The Health Care Directives Act*,[16] the right to make decisions relating to medical treatment.

With respect to children under the age of 16, the common law has developed the "mature minor rule" which provides that a "minor who has a full appreciation of the nature and consequences of medical treatment may consent to medical treatment".[17] While no "bright line" test exists, a court will consider the physical, emotional and intellectual maturity of the child, the nature of the parent-child relationship, the lifestyle of the minor, and the nature of the medical condition for which treatment is being sought.[18] Typically, very young children will not have capacity to consent, and their parents or legal guardians must do so on their behalf.[19]

E. CONSTITUTIONAL PROTECTION

The common law right to consent has been held to be protected by section 7 of the *Charter of Rights and Freedoms*. In *A.M.* v. *Benes*,[20] Justice Sutherland re-affirmed the constitutional nature of the right and stated that "codification" of the law of consent could not diminish common law rights unless it meets the "tests" of the *Charter*:

> I want to stress the constitutional entrenchment because there are in the materials filed on behalf of the Attorney General repeated references to provisions of the *Act* said to be "codifications" of the related common law. Historically, where there was no *Charter* dimension, statutory codifications have usually supplanted, within the ambit of the statute, the pre-existing substantive common law. Given that the statutes with which we are here concerned are closely related to the Ministry of Health, a vast and very powerful bureaucracy with many ties to the medical profession, given that medical science enjoys well earned prestige as one of the outstanding success stories of western civilization, and given the notable vulnerability of many of the persons for whom substitute decisions are made, and given the inevitability of continuing close connections among the Ministry of

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[14] *The Highway Traffic Act*, C.C.S.M. c. H60, s. 174.

[15] With parental consent: *National Defence Act*, R.S.C. 1985, c. N-5, s. 20(3).

[16] *The Health Care Directives Act*, C.C.S.M. c. H27, s. 4(2).

[17] *C.* v. *Wren* (1987), 35 D.L.R. (4th) 419 (Alta. C.A.); *Johnston* v. *Wellesley Hospital* (1971), 17 D.L.R. (3d) 139 (Ont. H.C.).

[18] MLRC, *Minors' Consent to Health Care*, *supra* n. 2 at 3.

[19] There is no doubt that parents have the right to consent to therapeutic treatment on behalf of an immature minor, but it may be that they do *not* have authority to consent to non-therapeutic treatment, such as sterilization. The decision of the Supreme Court of Canada in *Re Eve* (1986), 31 D.L.R. (4th) 1, suggests that only the court, exercising its *parens patriae* jurisdiction, can consent to such treatment - and even the court should not authorize non-therapeutic sterilization.

[20] *M. (A.)* v. *Benes* (1998), 166 D.L.R. (4th) 658 (Ont. Gen. Div.), add'l reasons at (1998), 173 D.L.R. (4th) 758 (Ont. S.C.J.), rev'd on other grounds (1999), 180 D.L.R. (4th) 72 (Ont. C.A.).

> Health, health practitioners and the Board, it is in my opinion crucially important to stress that the patient's rights here in issue are fundamental, constitutionally entrenched rights of a high order and that no amount of "codification" will diminish those rights unless the asserted codification meets the tests of the *Charter*.[21]

Thus, statutory changes to the common law of consent will only be effective if, and to the extent that, they meet the requirements of the *Charter*.

F. SUBSTITUTE CONSENT AT COMMON LAW

Persons who do not understand the nature and consequences of proposed treatment (generally minors and mentally incompetent adults) must rely on a substitute decision maker to make decisions regarding such treatment on their behalf.[22] At common law, only a court-appointed guardian (such as a committee) or the court itself, under its *parens patriae* jurisdiction, can consent to or refuse treatment on behalf of an incapable patient. It is worth noting that what is often at issue in cases of substitute consent is the question of consent to the *withdrawal* of medical treatment leading inevitably to the patient's death, which is obviously an immense responsibility for any substitute decision maker.

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[21] *Id.*, at 671-672.

[22] MLRC, *Advance Directives and Durable Powers of Attorney for Health Care* (Discussion Paper, 1990) in MLRC, *Self-Determination in Health Care (Living Wills and Health Care Proxies)* (Report #74, 1991) Appendix D, at 5.

CHAPTER 3

SUBSTITUTE CONSENT LEGISLATION

A. INTRODUCTION

A number of jurisdictions have enacted legislation that codifies, or clarifies, the common law regarding substitute consent in one way or another, and more have enacted legislation that changes the common law in specific situations. The latter type of legislation most commonly applies to situations regarding consent to treatment of mental health problems, a topic outside the scope of this Report.[1]

The following is a brief overview of the existing Manitoba legislation dealing with substitute consent, followed by a review of the relevant legislation in various other jurisdictions.

1. Manitoba Legislation

Under the current law, effective substitute consent to the provision or withdrawal of medical treatment can only be given by certain persons.

- At common law:
  - a parent or guardian may give consent for their minor child;
  - a physician may make a decision regarding treatment under the emergency doctrine (discussed above);
- Under *The Mental Health Act*:
  - A court appointed committee for both property and personal care may give consent on behalf of the person who is the subject of the committeeship order;
  - The Public Trustee may give consent if the Director of Psychiatric Services appoints the Public Trustee the committee of both property and personal care of a patient;
- Under *The Vulnerable Persons Living With a Mental Disability Act*, a person who has been appointed a substitute decision maker for personal care may make decisions regarding treatment within the scope of the terms of their appointment;
- A person who has been named as a "proxy" under *The Health Care Directives Act* may make decisions within the scope of their appointment.

Manitoba's existing legislation thus sets out the parameters for substitute decision making

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[1] For example, *The Mental Health Act*, C.C.S.M. c. M110.

with respect to persons with mental disorders,[2] persons with a mental disability,[3] and persons who have executed a health care directive.[4] *The Health Care Directives Act* permits a competent person over the age of 16 to appoint another person as a proxy to make health care decisions on their behalf in the event that they become unable to make such decisions. It also permits the creation of health care directives, which may express the maker's consent to, refusal of, or withdrawal of consent to particular health care treatments.[5] It appears likely that few people take advantage of this opportunity.[6]

The Mental Health Act provides that, where a person who has been admitted to a mental health facility[7] is not mentally competent to make treatment decisions, treatment decisions may be made on his or her behalf by: (a) a proxy appointed under *The Health Care Directives Act*; (b) if there is no proxy, a committee of both property and personal care appointed under the Act; (c) if no such committee has been appointed, the patient's nearest relative (or the Public Trustee, if no actual relative meets all the criteria); or (d) if a minor, his or her guardian.[8]

In addition, where a physician determines that a person who is *not* a patient in a mental health facility is incapable of personal care, the physician may certify that incapacity to the Director of Psychiatric Services, who may appoint the Public Trustee to act as a committee of both property and personal care for the person.[9] As well, the court may appoint a committee of both property and personal care for a person who is incapable of managing his or her property and also incapable of personal care.[10] If a physician advises the committee (whether the Public Trustee or another) that the patient is not mentally competent to make treatment decisions, the committee may then make those treatment decisions on the patient's behalf.[11] *The Mental Health Act* was substantially overhauled in 1999 and now provides guidance to substitute decision makers appointed under it as

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[2] *The Mental Health Act*, C.C.S.M. c. M110.

[3] *The Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90.

[4] *The Health Care Directives Act*, C.C.S.M. c. H27.

[5] *The Health Care Directives Act*, C.C.S.M. c. H27, ss. 4-4.1.

[6] B. Sneiderman, "Patients' Advance (Health Care) Directives" in B. Sneiderman, J. Irvine and P. Osborne, eds., *Canadian Medical Law* (3rd ed., 2003) 599 at 633-34.

[7] "Facility" is defined as "a facility for the observation, assessment, diagnosis and treatment of persons who suffer from mental disorders". *The Mental Health Act*, C.C.S.M. c. M110, s. 1.

[8] *The Mental Health Act*, C.C.S.M. c. M.110, s. 28.

[9] *The Mental Health Act*, C.C.S.M. c. M110, Part 8.

[10] *The Mental Health Act*, C.C.S.M. c. M110, Part 9.

[11] *The Mental Health Act*, C.C.S.M. c. M110, ss. 63(2) and 90(1).

to how they are to make decisions regarding medical treatment.[12]

The Vulnerable Persons Living with a Mental Disability Act, proclaimed in 1996, applies to persons who suffer from a "mental disability", other than persons to whom *The Mental Health Act* applies.[13] The Act sets up an elaborate system of support for decision making and substitute decision making for persons to whom it applies. This is intended to encourage such persons to make their own decisions, support them in making such decisions, and provide for substitute decision making only as a last resort. Where it does become necessary for a substitute decision maker to make a health care decision on behalf of a vulnerable person (as defined), the Act provides for the appointment of a "substitute decision maker for personal care", with only the powers specifically granted by the "Vulnerable Persons" Commissioner.[14] The legislation was the first in Manitoba to provide guidance to the substitute decision maker as to how decisions were to be made.[15] If the vulnerable person has appointed a proxy, or made a health care directive under *The Health Care Directives Act*, the appointment or directive pre-empts any appointment or health care decision to which the directive applies under *The Vulnerable Persons Living with a Mental Disability Act*.[16]

As well, *The Human Tissue Act* provides that, where a person has died without stipulating whether his or her body, or parts thereof, may be used for therapeutic or research purposes, the following persons may make that decision on their behalf: (a) a proxy appointed under *The Health Care Directives Act;* (b) if there is no proxy, the person's nearest relative (as defined by the Act); or (c) if there is no nearest relative, or the nearest relative is unavailable, by the person lawfully in possession of the body or the Inspector of Anatomy.[17]

Apart from these statutes, Manitoba has not enacted legislation that either codifies or supplants the common law with respect to substitute decision making.

2. Legislation in Other Canadian Jurisdictions

A number of provinces and territories have enacted legislation that deals with substitute decision making. The following is a brief review of the relevant history and types of statutory reform in those jurisdictions.

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[12] *The Mental Health Act*, C.C.S.M. c. M110, ss. 63, 93-96.

[13] "Mental disability" is defined as "significantly impaired intellectual functioning existing concurrently with impaired adaptive behaviour and manifested prior to the age of 18 years": *The Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90, s. 1(1).

[14] *The Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90, ss. 53-57.

[15] *The Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90, ss. 71-76.

[16] *The Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90, s. 68.

[17] *The Human Tissue Act*, C.C.S.M. c. H180, s. 3.

(a) Ontario

In 1992, Ontario codified the common law of informed consent in three separate but interrelated statutes, the *Consent to Treatment Act*,[18] the *Substitute Decisions Act*,[19] and the *Advocacy Act*.[20] The goal of this legislation was to "balance fundamental common law principles of self-determination and the protection of the rights of patients deprived of the mental capacity to make health care decisions."[21]

The legislative package was substantially amended in 1996 when the *Consent to Treatment Act* and the *Advocacy Act* were repealed, the *Substitute Decisions Act* was amended, and the *Health Care Consent Act, 1996* was enacted.[22] The *Health Care Consent Act, 1996* effectively underscores the need for consent in health care settings and is broader than its predecessors, creating a "statutory framework which regulates the obtaining of consent in three separate areas."[23] The activities covered by the Act include the administration of medical treatment, admission to health care facilities[24] and the provision of personal assistance service. For the purposes of this report, we will focus in Chapter 4, on the provisions dealing with consent to medical treatment which, unlike Manitoba's legislation, constitute a complete code.

(b) British Columbia

British Columbia introduced a package of legislation dealing with consent to health care, appointment of health care representatives and adult guardianship in 1993.[25] None of the legislation came into force until February 28, 2000, however, when only some parts of it were proclaimed.[26] (Most of the provisions relating to substitute consent to health care are now in force.)

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[18] *Consent to Treatment Act, 1992*, S.O. 1992, c. 31.

[19] *Substitute Decisions Act, 1992*, S.O. 1992, c. 30.

[20] *Advocacy Act, 1992*, S.O. 1992, c. 26.

[21] P. Osborne, "Consent to Treatment" in B. Sneiderman, J. Irvine, P. Osborne, eds., *Canadian Medical Law*, (3rd ed. 2003) 19 at 33.

[22] *Advocacy, Consent and Substitute Decisions Statute Law Amendment Act, 1996*, S.O. 1996, c. 2.

[23] M. McKelvey and L. Bohnen, *Ontario Health Legislation: An Annotated Guide* (1998) 1.

[24] This does not include hospitals or mental health facilities.

[25] *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181 (and Supp.), *Representation Agreement Act*, R.S.B.C. 1996, c. 405 (Supp.), *Adult Guardianship Act*, R.S.B.C. 1996, c. 6 (Supp.), and *Public Guardian and Trustee Act*, R.S.B.C. 1996, c. 383 (Supp.). All received Royal Assent on July 29, 1993.

[26] Portions of the legislation remain unproclaimed, and some of it has since been amended as well: *Adult Guardianship Statutes Amendment Act*, S.B.C. 2001, c. 2; *Health Care (Consent) and Care Facility (Admission) Amendment Act*, S.B.C. 2002, c. 46; *Miscellaneous Statutes Amendment Act (No. 3), 2003*, S.B.C. 2003, c. 96, ss. 28-36.

The legislation resulted from the recommendations of a Joint Working Committee on Adult Guardianship, which was struck in the fall of 1991 and released its final report in the fall of 1992.[27] Unlike Ontario, the British Columbia government rejected the idea of drafting a single omnibus statute, because it did not consider the various components to have sufficient commonality.[28] The provisions relating to substitute consent are almost wholly contained within the *Health Care (Consent) and Care Facility (Admission) Act*[29] and (like Ontario's legislation) constitute a comprehensive code.

The significant contribution of the Ontario and British Columbia statutory schemes lies in a clear and organized system of substitute decision making and the provision of review procedures.[30]

(c) Prince Edward Island

Prince Edward Island passed legislation in 1996 that dealt comprehensively with the issue of consent and substitute consent to health treatment, as well as advance health care directives and proxies, but it was not proclaimed into force until 2000.[31] The legislation was clearly modelled on the Ontario *Health Care Consent Act, 1996.*

(d) Yukon Territory

The Yukon Territory has had legislation since 1990 providing that patients may only be treated with their informed consent, defining competence for purposes of consent to treatment and defining who may provide consent on behalf of persons who are not competent to do so for themselves.[32] Following intensive public consultation, a legislative package was passed by the Legislature in December 2003 that replaced those provisions with the new *Care Consent Act.*[33] The new Act provides a more comprehensive codification of the rules relating to substitute consent and is expected to come into force in the fall of 2004.[34] (Although it is not yet in effect, references in this Report, unless otherwise noted, will be to the new legislation.)

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[27] R.M. Gordon, et al., *The 2002 Annotated British Columbia Representation Agreement Act, Adult Guardianship Act and Related Statutes* (2001) 2.

[28] *Id.*, at 5.

[29] *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181.

[30] Osborne, *supra* n. 21 at 34.

[31] *Consent to Treatment and Health Care Directives Act*, S.P.E.I. 1996, c. 10.

[32] *Health Act*, R.S.Y. 2002, c. 106, ss. 43-45.

[33] *Care Consent Act*, being Schedule B of the *Decision Making, Support and Protection to Adults Act*, S.Y. 2003, c. 21.

[34] "Government of Yukon Department of Health and Social Services, News Release #249, "New Bill Will Provide Tools for Decision Making, Support & Protection" (6 November 2003).

The *Care Consent Act* also provides for the appointment of health care proxies and the drafting of health care directives. It has clearly drawn heavily on the British Columbia statutory scheme.

(e) Québec

The Québec *Civil Code*[35] and the *Act Respecting Health Services and Social Services*[36] contain consent provisions similar to those found in the common law and legislation in the rest of Canada. As in the other provinces and territories, no one may be required to submit to medical treatment without their free (voluntary) and enlightened (informed) consent.[37] The legislation also provides that, where a person of full age is incapable of giving consent, consent may be given or refused on his or her behalf by an appropriate person, and lists those persons who are qualified to do so.[38]

(f) Alberta

The Alberta *Personal Directives Act*[39] was enacted in 1996 to implement a number of recommendations made in a 1993 joint report by the Alberta Law Reform Institute and the Health Law Institute.[40] The Act allows individuals to appoint substitute decision makers to make health care decisions on their behalf in the event of their incapacity and also provides for advance health care directives. The Alberta government did not, however, adopt a recommendation contained in that report that would have seen the enactment of a statutory list of proxy decision makers that would have applied where no advance health care directive was in place and no proxy had been appointed by the patient while capable.[41]

(g) Saskatchewan

Saskatchewan enacted *The Health Care Directives and Substitute Health Care Decision*

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[35] *Civil Code of Québec*, S.Q. 1991, c. 64.

[36] *Act Respecting Health Services and Social Services*, R.S.Q. c. S-4.2.

[37] *Civil Code of Québec*, S.Q. 1991, c. 64, arts. 10 and 11; *An Act Respecting Health Services and Social Services*, R.S.Q. c. S-4.2, ss. 8-10.

[38] *Civil Code of Québec*, S.Q. 1991, c. 64, art. 15; *An Act Respecting Health Services and Social Services*, R.S.Q. c. S-4.2, s. 12.

[39] *Personal Directives Act*, S.A. 1996, c. P-6.

[40] Alberta Law Reform Institute and Health Law Institute, *Advance Directives and Substitute Decision-Making in Personal Healthcare* (Report #64, 1993).

[41] *Id.*, at 8-9. Instead the *Dependent Adults Act*, R.S.A. 2000, c. D-11, s. 29, provides that under such circumstances treatment may be provided if two medical health professionals provide written opinions stating that it is necessary.

Makers Act[42] in 1997. The Act codifies the law of informed consent, as well as permitting the drafting of advance health care directives and the naming of health care proxies.

(h) Newfoundland

Newfoundland introduced legislation in 1995 dealing with substitute consent to health care,[43] implementing the recommendations of the Newfoundland Law Reform Commission in a 1992 Report.[44] Like the Saskatchewan legislation, it also deals with advance health care directives and the appointment of proxies (termed "substitute decision makers" in the legislation).

(i) Nova Scotia

In Nova Scotia, the *Hospitals Act* provides that patients *in hospital* cannot be treated without their consent.[45] Where a patient is incapable of consenting, the health care provider may obtain consent from specified substitutes.

As well, the *Medical Consent Act*[46] permits a competent adult to authorize another competent adult to make decisions regarding treatment on his or her behalf in the event that he or she loses his or her own competence.

(j) Other Canadian Jurisdictions

Every Canadian province and territory (with the exception of the Northwest Territories and Nunavut) has legislation allowing individuals to designate persons who may make health care decision on their behalf in the event of incapacity.[47] Most, as noted above, have also enacted legislation that provides for some form of advance health care directive. Five jurisdictions have yet to enact legislation that addresses the issue of substitute decision making in the absence of an applicable health care directive or appointed substitute decision maker: Manitoba, Alberta, New Brunswick, the Northwest Territories and Nunavut.

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[42] *The Health Care Directives and Substitute Health Care Decision Makers Act*, S.S. 1997, c. H-0.001

[43] *Advance Health Care Directives Act*, S.N. 1995, c. A-4.1

[44] Newfoundland Law Reform Commission, *Advance Health Care Directives and Attorneys for Health Care* (Discussion Paper #6, 1992).

[45] *Hospitals Act*, R.S.N.S. 1989, c. 208, s. 54(1).

[46] *Medical Consent Act*, R.S.N.S. 1989, c. 279.

[47] In addition to those described above, this includes New Brunswick"s *Infirm Persons Act*, R.S.N.B. 1973, c. I-8.

(k) Legislation in the United States

Decisions regarding health care in the United States have primarily been a matter falling within the jurisdiction of the individual states. Some states had legislation prior to 1990 authorizing either advance directives or the appointment of health care proxies (or both). Two events spurred the remaining states to enact such legislation and caused many states to enact legislation regarding the role of substitute decision makers. The first was the decision of the United States Supreme Court in *Cruzan* v. *Director, Missouri Department of Health*,[48] in which the Court held that the family of a young woman who had been in an irreversible coma for seven years did not have the right to authorize the discontinuance of her treatment. The second was the subsequent enactment of the *Patient Self-Determination Act*[49] by Congress in 1990, which required all states to provide patients in health care institutions with information regarding their rights around consent.

Every state now has legislation authorizing the appointment of health care proxies and all, except Massachusetts, Michigan and New York, authorize advance health care directives.[50] Many have also enacted statutes that establish a default list of substitute decision makers for purposes of consenting to health care.[51] In 1993, the National Conference of Commissioners on Uniform State Laws published the *Uniform Health-Care Decisions Act*[52] which was intended to standardize the welter of existing laws in the area. Because most states had already adopted legislation covering the same topic, however, the uniform statute has, to date, only been adopted in California, Delaware, Hawaii, Maine, Mississippi and New Mexico.[53] The individual state legislation varies in many of its details, but the *Uniform Act* reflects provisions found in many of the individual state enactments. The Commission has therefore restricted its review of United States law to the *Uniform Act*.

The *Uniform Act* acknowledges the right of competent individuals to decide all aspects of their own health care, including by means of appointing an agent to make such decisions on their behalf; facilitates the making of advance health care directives; sets out who is entitled to make decisions on behalf of an individual who has not prepared a directive or appointed a substitute; ensures that decisions made on an individual's behalf will, to the extent possible, be governed by his

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[48] *Cruzan* v. *Director, Missouri Department of Health*, 497 U.S. 261 (1990).

[49] *Patient Self-Determination Act*, enacted as sections 4206 and 4751 of the *Omnibus Budget Reconciliation Act of 1990*, Pub. L. No. 101-508.

[50] D.M. English, "The Uniform Health-Care Decisions Act and its Progress in the States" (2001) *Probate & Property*, online: <http://www.abanet.org/rppt/publications/magazine/2001/01my/01myenglish.html> (Date accessed: 7 May 2004).

[51] American Bar Association Commission on Law and Aging, *Health Care Surrogate Decision-Making Legislation, July 1, 2001*, online: <http://www.abanet.org/ftp/pub/aging/cal-7-2001.pdf> (Date accessed: 7 May 2004).

[52] National Conference of Commissioners on Uniform State Laws, *Uniform Health-Care Decisions Act* (St. NCCUSL, 1993), online: <http://www.law.upenn.edu/bll/ulc/fnact99-1990s/uhcda93.pdf> (Date accessed: 7 May 2004). (hereinafter referred to as the *Uniform Act*).

[53] English, *supra* n. 50.

or her own desires; requires (with certain exceptions) compliance by health care providers and institutes; and provides a procedure for the resolution of disputes.[54]

(l) Legislation in the United Kingdom

In the United Kingdom, the common law has developed a slightly different way than it has in Canada. There, the courts have held that (in the absence of a prior directive by the person), an action taken on behalf of a person who lacked the capacity to consent to that action is lawful under the "principle of necessity" if it was necessary, reasonable and in their best interests.[55] Thus, it is lawful for health care providers to provide treatment to incompetent individuals *without* their consent, real or substituted. Health care providers may also seek the approval of the court, under its *parens patriae* jurisdiction, in particular situations.[56] Apart from the court, therefore, there is no real concept of a "substitute decision maker" under English common law.

The English Law Commission recommended in 1995 that the common law principles should be codified to provide clarity to persons who may need to rely on it.[57] An omnibus bill dealing with mental incapacity was introduced into Parliament in 2003; it includes provisions codifying the existing law under the rubric of a "general authority" and defining what a person's "best interests" are for these purposes.[58] A Joint Committee of the House of Lords and House of Commons issued a report on the draft bill in November 2003, and the Government is expected to introduce revised legislation shortly.[59]

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[54]National Conference of Commissioners on Uniform State Laws, *supra* n. 52.

[55]*In re F (Mental Patient: Sterilisation)*, [1990] 2 A.C. 1.

[56]Department of Health, *Reference Guide to Consent for Examination or Treatment* (2001) 13.

[57]The Law Commission, *Mental Incapacity* (Report #231, 1995).

[58]*Draft Mental Incapacity Bill*, Cm 5859-1.

[59]The Joint Committee on the Draft Mental Incapacity Bill, *Report* (2003), online: <http://www.parliament.the-stationery-office.co.uk/pa/jt200203/jtselect/jtdmi/189/189.pdf> (Date accessed: 7 May 2004); Department for Constitutional Affairs, *The Government Response to The Scrutiny Committee's Report on the draft Mental Incapacity Bill* (February 2004), online: <http://www.dca.gov.uk/pubs/reports/mental-incapacity.html> (Date accessed: 2 May 2004).

CHAPTER 4

DISCUSSION

A. NEED FOR REFORM

As discussed in previous Chapters, there are presently gaps in the law of Manitoba as it relates to substitute decision making. In a scenario that is repeated daily in medical settings around the province, health care providers must decide whether or not to provide treatment to a person who does not have the capacity to consent to the treatment; the person has not completed an advance health care directive and has not appointed a proxy to act on his or her behalf. He or she became incompetent only recently, often late in life, and is not covered by *The Vulnerable Persons Living with a Mental Disability Act*. He or she is not institutionalized under *The Mental Health Act*. He or she has simply lost the capacity to consent.

In this situation, the health care provider may have the option of seeking to have the Public Trustee appointed as the committee for both property and personal care for the person, but it is not necessarily apparent that the person's incapacity is that extreme – and, in any event, the procedure is both time consuming and extremely intrusive, and the Public Trustee has no knowledge of the person's wishes, beliefs or values relevant to making a treatment decision on his or her behalf. In most cases, the health care provider will turn to the person's family for consent because, even though there is no legal justification for doing so, it is the most reasonable course of action in the circumstances.

A second implication of the present state of Manitoba law is that patients who have not prepared an advance health care directive, or appointed a health care proxy, are being deprived to some extent of their right to self-determination. There is no statutory mechanism to ensure that (to the extent possible) the person or people making health care decisions on their behalf are doing so in a manner of which they would have approved were they competent.

In addition, and quite apart from the importance of respecting the individual's right not to receive treatment unless it is appropriately authorized, health care professionals are exposed to risk by not having statutory guidelines that set out who is authorized to make treatment decisions where the patient is incapable of doing so:

> The failure to obtain a proper consent before treatment is administered can involve multifaceted liability. The health professional could be charged with the criminal offence of assault if consent is entirely absent or is vitiated by operation of law. There is the prospect of conventional tortious liability for assault and battery in circumstances of treatment without any consensual justification. ... Depending upon the nature of the violation, it is possible to sue for the infringement of a person's constitutional rights. Professional sanctions may also be enforced; a health care worker could be disciplined by his or her professional body, suffer a loss of employment, or face a reduction or elimination

of hospital privileges for violating the standards governing the administration of treatment.[1]

C arly, what is required is legislation that will comprehensively deal with the shortcomings of the present legislative scheme. It should be possible, in the interests of both patients and health care professionals, for decisions regarding treatment to be made on behalf of incapable patients without the need for resort to appointment of a committee for both property and personal care, with all the infringement of personal autonomy that process implies. It should also be possible to provide health care professionals with reliable guidelines that will enable them to make the most appropriate decisions with respect to the care of patients who are incapable of making their own decisions.

It may also be desirable to introduce a greater level of consistency in the law pertaining to substitute decision making. Under existing legislation, for example, it is not clear that a committee appointed under *The Mental Health Act* has the authority to *withdraw* consent to a medical treatment once the treatment is underway, whereas that authority is expressly included in *The Vulnerable Persons Living with a Mental Disability Act* and *The Health Care Directives Act*.[2] Consolidation in a single statute, to the extent practicable, of the law relating to substitute decision making regarding medical treatment would be preferable to the existing state of affairs.

B. OPTIONS FOR REFORM

It is the Commission's opinion that legislative reform in the area of substitute consent is necessary and overdue. At least three possible legislative reform options suggest themselves. Manitoba could follow the lead of either Ontario or British Columbia, which have dealt comprehensively with the issue of consent, including substitute consent, by way of legislation. (Prince Edward Island has generally adopted the Ontario model, while the Yukon has largely adopted the British Columbia model.) Alternatively, Manitoba could simply enact legislation to deal with the specific 'gap' areas identified earlier in this Report.

Finally, Manitoba could adopt a middle course, enacting legislation to deal with the identified gaps and to standardize provisions relating to substitute consent that are contained within existing legislation. The latter approach commends itself to the Commission as the most practical.

RECOMMENDATION 1

Legislation should be enacted to consolidate and standardize existing statutory provisions relating to substitute consent to health care and to address gaps in the existing legislation.

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[1] B.A. Kaiser, "Mental Disability Law" in J. Downie, T. Caulfield and C.M. Flood, eds. *Canadian Health Law and Policy* (2nd ed., 2002) 250 at 294.

[2] J.K. Knowlton, "Personal Decision Making: Is There a Trend to Empower the Disempowered and to Extend Decision Making?" in The Law Society of Manitoba, *Competence & Capacity: New Directions, The 2000 Isaac Pitblado Lectures* (2000) IV-1 at IV-8.

C. ENACTMENT BY AMENDMENT

It may not be necessary to enact an entirely new statute to address the problems identified by the Commission. Legislative reform may be effected through amendment of an existing statute; it would be a matter of identifying the most appropriate existing statute into which to incorporate it. The Commission is of the opinion that neither *The Mental Health Act* nor *The Vulnerable Persons Living with a Mental Disability Act* would be appropriate vehicles for the provisions in question, as the two address mutually exclusive subject matters and neither would be an obvious place for a non-legally trained person to look for the guidance that the Commission hopes these provisions will provide.

Another possibility would be to include the new provision in *The Health Care Directives Act*. That Act would then become similar in scope to the legislation found in several other provinces or territories in that it would deal with consent along with advance health care directives and health care proxies. This would be an advantage for persons who are familiar with the legislative regime in other Canadian jurisdictions and are seeking information on the applicable Manitoba provisions.

The main advantage to creating an entirely new statute would seem to be the fact that such a statute could be named in such a way that its scope (consent to health care) would be abundantly clear. It is not, in the Commission's opinion, necessary to create an entirely new statute; *The Health Care Directives Act* could easily be renamed to make its new, wider scope clear without adding to the existing profusion of related statutes.

RECOMMENDATION 2

***The legislation should take the form of an amendment to* The Health Care Directives Act, *with concomitant amendment of other affected legislation, and that Act should be named* The Consent to Treatment and Health Care Directives Act.**

D. FEATURES OF THE PROPOSED LEGISLATION

In the following section, the Commission will consider what specific provisions ought to be included in the new legislation in order best to accomplish its identified goals.

1. Codification of the Common Law of Consent

As noted previously (on page 6), there are four prerequisites to a valid consent at common law, with specific expectations and presumptions. Here, we consider whether these common law rules should be set out in legislation.

The common law relating to consent has not been codified in Manitoba. British Columbia, Ontario, Québec, Prince Edward Island, the Yukon Territory and (with respect to hospitalized patients only) Nova Scotia do have statutory provisions that codify the common law. The *Uniform Act* in the United States does not codify the common law relating to consent, except that it provides that individuals are presumed to have the capacity to make health care decisions.[3] In the United Kingdom, the common law is in the process of being codified,[4] although it differs markedly from the law in Canada.

The Commission has considered whether it is appropriate to recommend the codification of the common law of consent in Manitoba. Ultimately, we are content not to make any such recommendation, essentially for the same reasons we set out in our Report on *Minors' Consent to Health Care* in 1995.[5] At that time, we said:

> Codification has certain attractions. ... Legislation offers an opportunity for definitive declaration of the [law] which may be advantageous to physicians, minors and parents or guardians. Legislation also provides an opportunity to clarify some of the less certain aspects of the [law]....
>
> The disadvantages of codification must also be considered. Legislative wording tends to bring a new set of issues of interpretation. ... Legislation may also have unforeseen and unintended consequences. ... There is also the danger in legislation being too comprehensive and complex. ...
>
> A further concern is the danger that legislation may reduce the flexibility of the law by anchoring it to inflexible language which reflects contemporary policies and values and by impeding the development of the law to deal with a variety of unforeseen and future changes in society and medical practice. ... The pace of societal and medical developments creates significant difficulties for legislative reform in this area and periodic review and adjustment of such legislation would seem inevitable.

The Commission considers that, on balance, the law regarding consent to medical treatment is best left to be developed by the judiciary on an incremental basis.

Having said that, the Commission is keenly aware that, as is clear from the responses received to our Discussion Paper on *Withholding or Withdrawing Life-Sustaining Treatment*,[6] there is a need for clarity and guidance in this area of the law. In order to accomplish this without legislative intervention, we believe it would be worthwhile to adopt the approach which has been

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[3] National Conference of Commissioners on Uniform State Laws, *Uniform Health-Care Decisions Act* (1993), online: <http://www.law.upenn.edu/bll/ulc/fnact99/1990s/uhcda93.pdf> (Date accessed: 7 May 2004) s. 11.

[4] *Draft Mental Incapacity Bill*, Cmnd 5859-I.

[5] MLRC, *Minors' Consent to Health Care* (Report #91, 1995) 33-34.

[6] MLRC, *Withholding or Withdrawing Life-Sustaining Treatment* (Discussion Paper, 2002).

followed to date in the United Kingdom, where health authorities have prepared a great deal of literature about the rules regarding consent.[7]

RECOMMENDATION 3

That the Department of Health undertake a co-ordinated campaign of providing information with respect to substitute decision makers to the general public and, in particular, to patients and health care providers, similar to that instituted in the United Kingdom.

2. Capacity to Consent

In Manitoba, "capacity" is defined for purposes of *The Health Care Directives Act*, in section 2. which states:

> For the purpose of this Act, a person has capacity to make health care decisions if he or she is able to understand the information that is relevant to making a decision and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.[8]

The Vulnerable Persons Living with a Mental Disability Act defines "incapacity for personal care" (as it relates to health care) in similar language:

> For the purposes of this Act, a person is incapable of personal care if the person is not able to understand information that is relevant to making a decision concerning his or her own health care ... or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.[9]

The Mental Health Act requires that patients in mental health facilities be assessed with respect to their "competence to make treatment decisions".[10] In assessing that competence, the attending physicians must consider:

(a) whether the patient understands
  i) the condition for which the treatment is proposed,
  ii) the nature and purpose of the treatment,
  iii) the risks and benefits involved in undergoing the treatment, and
  iv) the risks and benefits involved in not undergoing the treatment; and
(b) whether the patient's mental condition affects his or her ability to appreciate the

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[7] See, for example, the material located on the UK Department of Health website at http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Consent/ConsentGeneralInformation/fs/en

[8] *The Health Care Directives Act*, C.C.S.M. c. H27, s. 2.

[9] *The Vulnerable Persons Living with a Disability Act*, C.C.S.M. c. V90, s. 46.

[10] *The Mental Health Act*, C.C.S.M. c. M110, s. 27(1).

consequences of making a treatment decision.[11]

While there is some consistency between this last definition and that found in the other two Acts, it is certainly not the same as them.

A number of jurisdictions have defined what the capacity to consent to medicall treatment means generally. Ontario's legislation, for example, states:

> A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.[12]

This language tracks that of Manitoba's *Health Care Directives Act* and *Vulnerable Persons Living with a Mental Disability Act* very closely. However, the Act additionally provides that "a person may be incapable with respect to some treatments and capable with respect to others" and "may be incapable with respect to a treatment at one time and capable at another".[13]

Prince Edward Island's *Consent to Treatment and Health Care Directives Act* includes similar provisions to the Ontario legislation, but adds two further requirements: the patient must be able to "understand that the information applies to his or her particular situation" (which is probably implicit in the Ontario Act) and also "understand that [he or she] has the right to make a decision".[14]

Newfoundland has legislation defining competence for the purposes of making an advance health care directive, which requires the maker to be "able to understand the information that is relevant to making a health care decision and able to appreciate the reasonably foreseeable consequences of that decision".[15]

Alberta defines "capacity", for purposes of the *Personal Directives Act*, as "the ability to understand the information that is relevant to the making of a personal decision [which includes consent to health care] and the ability to appreciate the reasonably foreseeable consequences of the decision".[16]

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[11] *The Mental Health Act*, C.C.S.M. c. M110, s. 27(2).

[12] *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 4(1).

[13] *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 15.

[14] *Consent to Treatment and Health Care Directives Act*, S.P.E.I. 1996, c. 10, s. 7.

[15] *Advance Health Care Directives Act*, S.N. 1995, c. A-4.1, s. 14.

[16] *Personal Directives Act*, S.A. 1996, c. P-6, s. 1(b).

The Saskatchewan *Health Care Directives and Substitute Health Care Decision Makers Act* employs a similar approach, but adds the requirement that the patient be able to *communicate* his or her health care decision.[17]

The Supreme Court of Canada has made it clear that under Ontario's legislation (and, by implication, the law of Manitoba, Prince Edward Island, Newfoundland, Alberta and Saskatchewan), a person need only be *able* to understand information or appreciate consequences, not necessarily *actually* understand or appreciate them, to be considered capable of making decisions regarding treatment.[18]

The *Uniform Act* in the United States similarly defines "capacity" as "an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health-care decision".[19] The proposed Mental Incapacity Bill in the United Kingdom provides:

> 1(1) For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment or a disturbance in the functioning of the mind or brain.
>
> ...
>
> 2(1) ... [A] person is unable to make a decision if –
>
> (a) he is unable to understand the information relevant to the decision,
>
> (b) he is unable to retain the information relevant to the decision,
>
> (c) he is unable to use the information relevant to the decision as part of the process of making the decision, or
>
> (d) he is unable to communicate the decision (whether by talking, using sign language, or other means).[20]

The British Columbia and Yukon statutes both differ from the legislation in the jurisdictions discussed above in that they state that, when determining capacity, the health care provider is to base his or her decision on whether or not the patient *demonstrates that they understand* the information provided to them, and that the information applies to their situation.[21] *Actual* understanding, and not merely the *ability* to understand, is thus the test in British Columbia and the Yukon.

A similar test applies in Nova Scotia where the *Hospitals Act* requires an examining

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[17] *The Health Care Directives and Substitute Health Care Decision Makers Act*, S.S. 1997, c. H-0.001, s. 2(1)(b).

[18] *Starson v. Swayze* (2003), 225 D.L.R. (4th) 385 (S.C.C.).

[19] National Conference of Commissioners on Uniform State Laws, *supra* n. 3, s. 1.

[20] *Draft Mental Incapacity Bill*, Cm. 5859-1, clauses 1 and 2.

[21] *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181, s. 7; *Care Consent Act*, being Schedule B of the *Decision Making, Support and Protection to Adults Act*, S.Y. 2003, c. 21, s. 6(2).

psychiatrist to consider whether or not the patient

(a) understands the condition for which the treatment is proposed;
(b) understands the nature and purpose of the treatment;
(c) understands the risks involved in undergoing the treatment;
(d) understands the risks involved in not undergoing the treatment; and
(e) whether or not [*sic*] his ability to consent is affected by his condition.[22]

There are no criteria set out in the Québec *Civil Code* for determining capacity to consent to medical treatment and, as a result, the courts in that province have adopted the Nova Scotia standards.[23]

The Commission is persuaded that a single definition of capacity should apply in Manitoba. It is not persuaded that there is a need to adopt the British Columbia/Yukon model of defining capacity as *actual* understanding, as contrasted with the existing definitions of *ability* to understand.

Furthermore, the Commission does not consider it necessary to add to the definition of "capacity" the gloss added by Prince Edward Island requiring the patient to understand that he or she has the *right* to make a decision, or that added by Saskatchewan of requiring the patient to be able to *communicate* his or her decision. If an individual is able to understand the relevant information and the consequences of making (or failing to make) a decision, it is neither necessary nor desirable to require the health care provider to go further and test his or her ability to understand his or her *right* to make a decision.

As for requiring the patient to be able to communicate his or her decision, such a requirement could be interpreted as placing the onus on patients to be able to communicate, instead of on the health care provider to be able to understand. This could be prohibited by the decision of the Supreme Court of Canada in *Eldridge* v. *British Columbia (AttorneyGeneral)*.[24] *Eldridge* involved two sets of plaintiffs: a hearing impaired woman and a hearing impaired married couple. In both situations, the patients were capable of giving consent and making treatment decisions, but their health care providers were unable to convey and receive information effectively because they could not overcome the barrier to communication caused by the combination of the patients' hearing impairment and the staff's inability to communicate using sign language. The Supreme Court of Canada held that the failure of the medical system to provide sign language interpretation constituted a *prima facie* violation of the rights of the hearing impaired persons under section 15(1) of the *Charter*. Legislation permitting treatment without consent on the basis of the patient's inability to communicate may therefore be vulnerable to a similar *Charter* challenge. Such legislation locates the source of the problem with the patient – as having a disability which prevents the communication from taking place – when, in fact, both the patient and the health care provider share the disability.

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[22] *Hospitals Act*, R.S.N.S. 1989, c. 208, s. 52(2). As stated earlier, this legislation only applies to patients in hospitals.

[23] R. Kouri and S. Philips-Nootens, "Civil Liability of Physicians under Quebec Law" in J. Downie, T. Caulfield and C.M. Flood, eds., *Canadian Health Law and Policy* (2nd ed., 2002) 533 at 557.

[24] *Eldridge* v. *British Columbia (Attorney General)*, [1997] 3 S.C.R. 624.

On balance, the Commission is satisfied that the existing definition of "capacity" in *The Health Care Directives Act* is adequate. It could be improved, however, if it clarified (as the Ontario and Prince Edward Island legislation does) that capacity can vary from time to time, and that a person may be capable with respect to some treatments and not with respect to others. The same definition should apply to *The Vulnerable Persons Living with a Mental Disability Act* and to *The Mental Health Act*.

RECOMMENDATION 4

The definition of "capacity" in the Act should provide that a person may be incapable with respect to some treatments and capable with respect to others, and may be incapable with respect to a treatment at one time and capable at another.

RECOMMENDATION 5

***The Act's definition of "capacity" should also apply to* The Vulnerable Persons Living with a Mental Disability Act *and* The Mental Health Act.**

3. Hierarchy of Substitute Decision Makers

The determination of who exactly is entitled to act as a substitute decision maker is what the Commission primarily wished to consider in this Report. If a proxy named under *The Health Care Directives Act*, a committee appointed under *The Mental Health Act* or a substitute decision maker for personal care appointed under *The Vulnerable Persons Living with a Mental Disability Act* is available and has the relevant authority, he or she will be the person entitled. In the absence of such a person, and in the absence of statutory guidelines (except in the case of an immature minor), no one but the court is legally entitled to make a decision regarding treatment. As previously noted, the practice among health care providers is typically to look first to the patient's spouse for consent. If there is no spouse available, they will look to adult children; if no children are available, they will look to parents, followed, if necessary, by (in order) siblings, grandparents, grandchildren, uncles or aunts, and nephews and nieces.[25] If there are no family members available, an application to the court may be necessary before treatment may be provided (or withdrawn, as the case may be).

A similar "hierarchy" of substitutes has been reproduced, modified from this example to a greater or lesser extent, in all legislation providing for substitute consent. The Ontario *Health Care Consent Act*, for example, sets out the following hierarchy:[26]

- guardian of the person (similar to a committee for personal care appointed under *The Mental Health Act*);

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[25] This hierarchy is based on the definition of "nearest relative" in *The Mental Health Act*, C.C.S.M. c. M110, s. 1, which has no legal effect other than in the circumstances set out in that Act.

[26] *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 20.

- attorney for personal care (similar to a proxy appointed under *The Health Care Directives Act*);
- representative appointed by the Consent and Capacity Board (no analogy in Manitoba or elsewhere);
- spouse or partner (unless legally separated);
- child or custodial parent, or individual/agency authorized to consent in place of the parent;
- non-custodial parent;
- sibling;
- any other relative;
- Public Trustee and Guardian.

Prince Edward Island gives priority to a proxy over a court-appointed guardian (as does Manitoba's existing legislation).[27] Its *Consent to Treatment and Health Care Directives Act* also includes, following the "sibling" category and preceding the "any other relative" category, "a person whom the health practitioner considers to be the patient's trusted friend with close knowledge of the wishes".[28] As Prince Edward Island does not recognize same-sex partners as equivalent to spouses for purposes of the Act, this may be a way of providing such persons with some right of involvement, albeit inferior to that of all members of the patient's immediate family. However, in our view, there are situations in which it would be appropriate to turn to a trusted friend for substitute decisions. For example, many people do not have close relatives but do have several close friends who would be aware of their wishes. One would hope that they would, in such cases, appoint someone under *The Health Care Directives Act* as a substitute decision maker or health care proxy, but as stated earlier, unfortunately, it appears that many people may not take advantage of this option, for whatever reason.[29] We therefore favour the addition of this category to the statutory list.

British Columbia's hierarchy is only slightly different from Ontario's:[30]

- court-appointed substitute decision maker or guardian with the relevant authority;
- representative (similar to a proxy);
- spouse (defined to include common law and same-sex partners), unless legally separated;
- child;
- parent;
- sibling;

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[27] *The Mental Health Act*, C.C.S.M. c. M110, s. 91.

[28] *Consent to Treatment and Health Care Directives Act*, S.P.E.I. 1996, c. 10, s. 11.

[29] See *e.g.*, Alberta Law Reform Institute and Health Law Institute, *Advance Directives and Substitute Decision-Making in Personal Healthcare* (Report #64, 1993) 8; see also, B. Sneiderman, "Patients' Advance (Health Care) Directives" in B. Sneiderman, J. Irvine and P. Osborne, eds., *Canadian Medical Law* (3rd ed., 2003) 599 at 633-634.

[30] *Health Care (Consent) and Health Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181, ss. 11 and 16.

- anyone else related by birth or adoption;
- a person appointed by the Public Guardian and Trustee.

In Québec, priority is given to a formally appointed substitute, such as a mandatary, tutor or curator (where the scope of their authority includes making such decisions).

Note that under the Québec *Civil Code* only a mandatary, tutor or curator may give substitute consent for care that is not required by the person's state of health (such as cosmetic surgery); if the care poses a serious risk of harm or might cause grave or permanent effects, court approval is required.[31]

In Nova Scotia, the health care provider may obtain consent from the guardian appointed by court or a proxy; if there is no guardian or proxy, from the spouse or common law partner or from the "next of kin". If no spouse, common law partner, or next of kin is "available" (which is not defined in the Act), the Public Trustee may provide substitute consent.[32] The Act does not define who may be considered "next of kin", nor does it establish a system of priority amongst family members or as between spouses or common law partners and family members.

In the Commission's opinion, neither the Québec nor the Nova Scotia examples provide particularly useful guidelines for choosing substitute decision makers.

The default substitute decision maker in Newfoundland, which otherwise has a statutory list very similar to the one in Manitoba's *Mental Health Act*, is the responsible health care provider. Again this is not a model that the Commission would see as appropriate (except in emergencies), given the importance of empowering the incapable patient and preventing potential conflicts of interest for the health care providers involved.

The hierarchy set out in the United States *Uniform Act* is very close to the informal guidelines presently in use in Manitoba: a guardian or proxy; a spouse (unless legally separated); an adult child; a parent; or a sibling.[33] That Act introduces a new possibility, however: in the absence of a guardian or formally appointed proxy, a patient may designate any individual to act as a substitute by personally informing their supervising health care provider of their wish, and the health care provider must note that designation on the patient's medical chart.[34] The Commission sees this as a potentially very useful development.

Permitting a patient orally to designate a substitute to their health care provider maximizes

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[31] *Civil Code of Québec*, S.Q. 1991, c. 64, art. 18.

[32] *Hospitals Act*, R.S.N.S. 1989, c. 208, s. 54.

[33] National Conference of Commissioners on Uniform State Laws, *supra* n. 3, s. 5.

[34] National Conference of Commissioners on Uniform States Law, *supra* n. 3, ss. 5(b) and 7(b).

the ability of the patient to control his or her own treatment. There are, of course, obvious risks. In our Report on *Self-Determination in Health Care (Living Wills and Health Care Proxies)*, we said:

> Because of the inherent lack of reliability associated with one person recalling another person's prior oral statements, oral health care directives should not be allowed under our scheme.[35]

The limited form of oral directive recommended in the United States, however, minimizes the risks that concerned the Commission in 1991. In conjunction with the prohibition on owners, operators, or employees of residential long-term health care institutions acting as substitutes, it ensures as far as possible that the wishes of a patient, who later becomes incapable, are respected. *Oral* designation of owners, operators and employees is prohibited because oral designation of such persons potentially puts the patient's health care providers in the invidious position of being the only witness to an oral designation of themselves. There are no restrictions on a written designation of such a person because there are safeguards around the process of designating someone in writing (witnesses, etc.) that are absent when the designation is made orally. If the health care provider is indeed the patient's preferred choice of substitute, there is nothing preventing the health care provider from arranging a *written* designation. The *Uniform Act*'s provision has been described as follows:

> Although the Commissioners ... indicated a preference for written powers of attorney [similar to Manitoba's proxy], they also recognized that many individuals simply will fail to prepare the necessary documents. Furthermore, the Commissioners recognized that oral designations occur with some frequency in practice. The ease with which oral designations can be made creates a significant risk of miscommunication, however. To provide some reliability of proof, an individual may orally designate a surrogate only by personally informing the individual's supervising health care provider. In turn, the UHCDA obligates the health care provider to record the designation in the individual's health care record.
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> ... [The oral surrogacy provision] is the most successful of the UHCDA's innovations.[36]

The Commission agrees and believes that a similar provision should be enacted in Manitoba. Apart from this innovation, however, we see no reason to adopt a hierarchy that differs markedly from that currently in use. It was suggested to the Commission that the hierarchy set out in *The*

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[35] MLRC, *Self-Determination in Health Care (Living Wills and Health Care Proxies* (Report #74, 1991) 12.

[36] D.M. English, "The Uniform Health-Care Decisions Act and its Progress in the States", (2001) *Probate & Property*, online: <http://www.abanet.org/rppt/publications/magazine/2001/01/mj/01mjenglish.html> (Date accessed: 4 May 2004) 5. Rather than the US term "supervising health care provider", the Commission would recommend the use of the term "most responsible physician", as suggested by the Manitoba College of Physicians and Surgeons and endorsed by us in MLRC, *Withholding or Withdrawing Life Sustaining Medical Treatment* (Report #109, 2003) 17.

Mental Health Act for purposes of that Act should be adopted more widely[37] and, for the most part, the Commission agrees with that suggestion. It should be clear in the legislation that health care providers must choose the first available and highest ranked qualified person (or persons, if more than one is equally highly ranked and qualified) from the list; "shopping around" for a favourable decision is not permissible.

RECOMMENDATION 6

When a patient is determined to be incapable with respect to a treatment decision, consent to the treatment should be sought from the highest ranked of the following persons (subject to their reasonable availability):

a) a proxy appointed under the Act with the relevant authority;
b) a substitute decision maker for personal care appointed under The Vulnerable Persons Living with a Mental Disability Act with the relevant authority;
c) a committee of both property and personal care appointed under The Mental Health Act, including the Public Trustee, with the relevant authority;
d) a spouse or common law partner, unless living separate and apart from the patient;
e) children;
f) parents;
g) a person whom the health practitioner considers to be the patient's trusted friend with close knowledge of the patient's wishes;
h) siblings;
i) grandparents;
j) grandchildren;
k) uncles and aunts;
l) nephews and nieces; or
m) the Public Trustee.

RECOMMENDATION 7

The Act should be amended to permit a patient orally to designate a proxy to the health care provider responsible for their care if no valid written designation exists. If a patient designates a proxy in this manner, the health care provider should be obligated to record that designation on the patient's medical record.

RECOMMENDATION 8

A patient should not be able orally to designate as a substitute decision maker an

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[37]Memorandum, dated September 30, 2002, from M. Anne Bolton, Q.C., Manitoba Public Trustee, in response to the MRLC Discussion Paper on *Withholding or Withdrawing Life-Sustaining Treatment* (June 2002).

owner, operator, or employee of a residential long-term health care facility in which he or she is resident.

4. Qualifications of Substitute Decision Makers

It is not enough for a health care provider simply to choose the highest ranking person on the statutory list of potential substitute decision makers, however. There are certain additional requirements that must also be met before a person can be considered able to make health care decisions on behalf of someone else.

At present, in order to be appointed a proxy under *The Health Care Directives Act*, a person need only be "apparently mentally competent" and at least 18 years old.[38] Being appointed as a substitute decision maker for personal care under *The Vulnerable Person Living with a Mental Disability Act* requires that a person be, in the opinion of the Vulnerable Person's Commissioner, "apparently capable, suitable and able to act", and "not ... in a position where his or her interests conflict with the vulnerable person's interests...."[39]

A patient's nearest relative may act as a substitute decision maker under *The Mental Health Act* if there is no relevant proxy and no committee of both property and personal care, but *only* if he or she is an adult, is apparently mentally competent, has been in personal contact with the patient within the previous 12 months, and is available and willing to assume the responsibility for making treatment decisions.[40]

There are certain requirements common to all, or most, jurisdictions that have legislation dealing with substitute health care decision making. Most require that the substitute decision maker be an adult (unless he or she is a parent or spouse of the patient)[41] although Ontario and Prince Edward Island have lowered the relevant age to 16.[42] Most also require that the substitute decision maker be available and willing to assume the responsibilities imposed by the relevant legislation.[43]

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[38] *The Health Care Directives Act*, C.C.S.M. c. H27, s. 12.

[39] *The Vulnerable Person Living with a Mental Disability Act*, C.C.S.M. c. V90, s. 54(1). The scope of this latter restriction is set out with some specificity in section 54(2).

[40] *The Mental Health Act*, C.C.S.M. c. M110, ss. 1 and 28.

[41] *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181, s. 16(2); *Advance Health Care Directives Act*, S.N. 1995, c. A-4.1, s. 10; *The Health Care Directives and Substitute Health Care Decision Makers Act*, S.S. 1997, c. H-0.001, s. 15; *Care Consent Act*, being Schedule B of the *Decision Making, Support and Protection to Adults Act*, S.Y. 2003, c. 21, s. 12(2).

[42] *Health Care Consent Act, 1996*, S.O. 1996, c. 1, Sch. A, s. 20(2); *Consent to Treatment and Health Care Directives Act*, S.P.E.I. 1996, c. 10, s. 11.

[43] *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181 (Supp.), s. 16(1); *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 20(2); *Consent to Treatment and Health Care Directives Act*, S.P.E.I. 1996, c. 20, s. 11; *The Health Care Directives and Substitute Health Care Decision Makers Act*, S.S. 1997, c. H-0.001, s. 15; *Care Consent Act*, being

(continued...)

In addition, however, there are some unique or unusual requirements, particularly in recently enacted legislation. The new Yukon legislation, for example, (building on the British Columbia legislation)[44] disqualifies a person who has "a conflict with the care recipient that raises a reasonable doubt whether they will comply with the duties [imposed by the Act]".[45] While this injects a certain amount of subjectivity into the selection process, it does provide flexibility that allows health care providers to choose *appropriate* substitutes in situations where they are aware of conflicts between patients and potential substitutes.

Ontario also prohibits a person from being appointed an attorney for personal care (proxy) if he or she provides health care or residential, social, training or support services to the patient for compensation (unless they are spouses, partners or relatives).[46] The same circumstance has been addressed in a more limited way by the United States *Uniform Act*, which simply prohibits owners, operators and employees of long-term residential health care providers from acting as substitute decision makers on behalf of any of their residents (unless the individual is related to them by blood, marriage or adoption).[47] The Commission considered similar restrictions in its report on *Self-Determination in Health Care* in 1991 and rejected them because we felt that such "presumptions of untrustworthiness ... [are] unfair and an unreasonable restraint on the discretion of the maker to appoint the individual in whom he or she has the greatest confidence".[48]

In a different vein, the relatively recent Prince Edward Island legislation introduces a requirement that the substitute decision maker have "knowledge of [the patient's] circumstances", and have been "in recent contact" with the patient. This is again less objective than a requirement that simply stipulates a time period within which the two must have had some "contact" (as is found, for example, in *The Mental Health Act*), but helps to ensure that the most appropriate possible person is making what are potentially life and death decisions on behalf of the incapable patient.

It would be possible for Manitoba simply to adopt, with respect to substitute decision makers, the requirements of any of *The Mental Health Act*, *The Vulnerable Persons Living with a Mental Disability Act*, or *The Health Care Directives Act*, although it is not immediately obvious which would be most appropriate. Another option would be to adopt an amended set of requirements that would apply to some or all of those three Acts, in addition to the substitute decision makers with whom this Report is primarily concerned.

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[43](...continued)
Schedule B to the *Decision Making, Support and Protection to Adults Act*, S.Y. 2003, c. 21, s. 12(2); National Conference of Commissioners on Uniform State Laws, *supra* n. 3, ss. 1 and 5(b).

[44]*Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181, s. 16(2).

[45]*Care Consent Act*, being Schedule B to the *Decision Making, Support and Protection to Adults Act*, S.Y. 2003, c. 21, s. 12(2).

[46]*Substitute Decisions Act, 1992*, S.O. 1992, c. 30, s. 46(3).

[47]National Conference of Commissioners on Uniform State Laws, *supra* n. 3, s. 2(b).

[48]MLRC, *supra* n. 35, at 14.

On balance, the Commission considers the latter option the most desirable. The existing sets of statutory requirements are not entirely satisfactory, and it would be beneficial to amend them to make them not only as efficacious as possible, but also consistent with each other. The Commission considers that any provisions relating to the category of substitute decision makers with which this Report is primarily concerned should also apply to proxies, as well as to substitute decision makers appointed under *The Vulnerable Persons Living with a Mental Disability Act* and section 28 of *The Mental Health Act*.

The Commission is particularly impressed by some of the innovations adopted recently in other jurisdictions (specifically, the Yukon and Prince Edward Island) to ensure that the person making a health care decision on behalf of an incapable patient is the best possible person in the circumstances. The Commission does not, however, consider it desirable to lower the age at which a person may make substitute health care decisions, as has been done in Ontario and Prince Edward Island, for the reason set out in our 1991 Report on *Self-Determination in Health Care*[49] – in essence, that making potentially critical health care decisions on behalf of another person requires greater maturity than making the same kinds of decisions on one's own behalf.

RECOMMENDATION 9

Persons should not be eligible to act as substitute decision makers under the Act, under* The Vulnerable Persons Living with a Mental Disability Act, *or under section 28 of* The Mental Health Act *unless they:

a) are at least 18 years old (unless they are the parent or spouse of the person on whose behalf they are to make a decision);
b) are capable of consenting to the treatment proposed;
c) are available to make a decision;
d) are willing to assume the responsibilities imposed by the Act;
e) have no conflict with the patient that raises a reasonable doubt whether they will comply with the duties imposed by the Act;
f) have knowledge of the patient's circumstances; and
g) have been in recent contact with the patient.

Requirements a) through d) should also apply to proxies making health care decisions.

The United States *Uniform Act* also permits an individual to disqualify any other person, including family members, from acting as their substitute decision maker, either in writing or by personally informing their supervising health care provider.[50] Newfoundland permits a similar

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[49]MLRC, *supra* n. 35, at 14.

[50]National Conference of Commissioners on Uniform State Laws, *supra* n. 3, s. 5(h). Again, the health care provider is obliged to record the disqualification on the patient's medical chart. s. 7(b).

disqualification, although it may be overridden by the court.[51] Such an option has also been recommended by law reform commissions in both Alberta[52] and Nova Scotia.[53] The Commission considers such a provision to be extremely helpful. Families being what they are, there is always the possibility that conflicts exist that would make a close family member quite the wrong person to be making important health care decisions on behalf of an incapable patient. In the absence of an advance health care directive, or in situations where the patient's proxy of choice is not available or incapable of making a decision, it seems to the Commission to be highly desirable to provide patients with the ability to avoid the decision being made on their behalf by someone whom they would not wish to have that power.

RECOMMENDATION 10

The Act should be amended to permit individuals to designate in an advance health care directive other persons, including family members, who may not act as substitute decision makers on their behalf. It should also be possible to make such a designation orally by informing the health care provider, who should be obligated to note any such designation on the individual's medical chart.

5. Resolution of Disputes Among Substitute Decision Makers

It can, of course, often happen that more than one person is equally entitled to make a health care decision on behalf of an incapable patient. Those persons will often feel very strongly about the merits of a decision to consent to, or refuse, treatment and it is inevitable that occasionally disagreements will arise. It is incumbent upon the Legislature to ensure that, in such situations, a mechanism exists to resolve the dispute so that health care providers can know whether the consent to treatment (or refusal of treatment) that they have obtained is legally valid. A fair and appropriate mechanism will also provide certainty to relatives and friends of incompetent individuals and minimize conflict that can aggravate an already emotionally charged situation.

Manitoba's existing legislative scheme gives priority, in most circumstances, to proxies appointed under *The Health Care Directives Act*.[54] If there has been more than one person appointed as a proxy, the Act deems them to have been appointed to act in succession (so that only one at a time has the power to actually make any decisions), unless the directive indicates that they are to act

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[51] *Advance Health Care Directives Act*, S.N. 1995, c. A-4.1, s. 10(3).

[52] Alberta Law Reform Institute and Health Law Institute, *Advance Directives and Substitute Decision-Making in Personal Healthcare* (Report #64, 1993) 36.

[53] Law Reform Commission of Nova Scotia, *Reform of the Laws Dealing with Adult Guardianship and Personal Health Care Decisions: Final Report* (1995) 40.

[54] *The Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90, ss. 4 and 68; *The Mental Health Act*, C.C.S.M. c. M110, ss. 28 and 91.

jointly.[55] If they are appointed jointly, the Act provides that decisions are made by the majority of those appointed and, if there is no majority, the person first named in the directive has the authority to make the decision.

The Vulnerable Persons' Commissioner may appoint two or more persons as substitute decision makers for personal care, to act jointly or otherwise, under *The Vulnerable Persons Living with a Disability Act*.[56] In the event of a disagreement between or among those persons, the Commissioner "shall endeavour to mediate between the substitute decision makers and seek to resolve the dispute".[57]

The Mental Health Act practically ensures that only one person is entitled to make substitute health care decisions with respect to a given patient at any given time, thereby precluding disputes by providing that within its ranking of "nearest relatives" the person entitled to make decisions is

> ... the adult person first listed in the following clauses, relatives of the whole blood being preferred to relatives of the same description of the half-blood and the elder or eldest of two or more relatives described in any clause being preferred to the other of those relatives, regardless of gender ....[58]

Other jurisdictions have dealt with conflict among substitute decision makers in a variety of ways. Few have made provision to deal with disputes among proxies (although Newfoundland has removed the possibility of such disputes by only allowing the appointment of a single proxy).[59] Most, however, have created some method of resolving disputes among persons who are equally entitled to make a decision on the basis of the statutory categories.

Some jurisdictions have schemes that turn decision making authority over to a third party if the statutory decision makers cannot agree. In British Columbia, if there is a dispute about which individual is entitled under the *Health Care (Consent) and Care Facility (Admission) Act* to make the decision, the health care provider must request the Public Guardian and Trustee to authorize someone to make the decision.[60] In Ontario, where two or more equally qualified persons disagree about whether to give or refuse consent, the Public Guardian and Trustee will actually make the

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[55] *The Health Care Directives Act*, C.C.S.M. c. H27, s. 15(1).

[56] *The Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90, s. 55(1).

[57] *The Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90, s. 119.

[58] *The Mental Health Act*, C.C.S.M. c. M110, s. 1.

[59] *Advance Health Care Directives Act*, S.N. 1995, c. A-4.1, s. 3.

[60] *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181, s. 16(3).

decision instead.[61] The rules are similar in Prince Edward Island, except that the ultimate decision maker is described as "such public official as may be empowered with the duty of public guardianship or as may be designated by the Minister".[62] The Yukon *Care Consent Act* provides that, if two or more qualified persons disagree about giving or refusing consent, they or the health care provider may ask the Capability and Consent Board to make the decision.[63]

In Newfoundland, on the other hand, the decision of the majority of qualified persons within a single category prevails; if there is no majority, the right to make the decision reverts to the category of persons next on the list.[64] The United States *Uniform Act* imposes a similar but more drastic solution: if more than one member of a class has authority to act as a substitute decision maker, and there is no majority decision, no one (except a person from a category higher up on the priority list) has the authority to make the decision; recourse to the court would then likely become necessary.[65] Presumably, the intention of such provisions is to encourage the disagreeing decision makers to seek a consensus, lest the right to make the decision falls to someone less sensitive to the patient's wants and needs. It does carry with it, however, a risk that the decision will indeed be made by such a person if the parties in dispute cannot, in fact, reach agreement.

Saskatchewan has adopted essentially the same rules with respect to statutory substitute decision makers that are found in Manitoba's *Mental Health Act*, giving priority to the older or eldest member within a given category who is related by "full blood".[66]

Until recently, the Québec *Civil Code* provided that a "spouse, closest relative or any interested party" could give consent when there was no mandatary, tutor or curator in place. This simple list of substitute decision makers had the potential of leading to conflict, as it gave no priority as between close relatives, or as between close relatives and a person showing a special interest in the incapable patient. This was remedied, to some extent, by recent legislation extending marital rights and obligations to cohabiting couples of the opposite or same sex. The relevant provision in the *Civil Code* now provides:

> Where it is ascertained that a person of full age is incapable of giving consent to care required by his or her state of health, consent is given by his or her mandatary, tutor or curator. If the person of full age is not so represented, consent is given by his or her married, civil union or *de facto* spouse or, if the person has no spouse or his or her spouse

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[61] *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 20(6).

[62] *Consent to Treatment and Health Care Directives Act*, S.P.E.I. 1996, c. 10, s. 11(6).

[63] *Care Consent Act*, being Schedule B of the *Decision Making, Support and Protection to Adults Act*, S.Y. 2003, c. 21, s. 14.

[64] *Advance Health Care Directives Act*, S.N. 1995, c. A-4.1, s. 11.

[65] National Conference of Commissioners on Uniform States Laws, *supra* n. 3, s. 5(c).

[66] *The Health Care Directives and Substitute Health Care Decision Makers Act*, S.S. 1997, c. H-0.001, s. 15.

is prevented from giving consent, it is given by a close relative or a person who shows a special interest in the person of full age.[67]

Thus, Québec now avoids the situation where a sibling or parent has a superior entitlement to the patient's life partner. However, the *Civil Code* still does not provide a hierarchy as between other relatives and "interested" parties, so there is still significant potential for conflict and no means of authoritatively resolving it without an application to court.

The Commission considers it important to make provision for an efficient and effective mechanism for resolving disagreements among substitute decision makers. The interests of the incapable patient are not best served by requiring litigation to resolve such disagreements, as do the Québec *Civil Code* and the United States *Uniform Act*. Nor is it clearly more desirable to require the involvement of the Public Trustee (or equivalent), as has been done in Ontario, British Columbia and Prince Edward Island, or the Capability and Consent Board, as in the Yukon. The Commission would prefer that the people involved in a disagreement, including the health care providers, have a clear and unambiguous method for resolving disputes so long as that method will also be likely to result in the best possible decision being made on behalf of the incapable person.

The mechanism set up by *The Mental Health Act* appears to the Commission to provide certainty and predictability. It does not obviously, however, lead to the best possible decision being made on behalf of the incapable patient, as there is no reason to believe that a person will make a better decision than someone otherwise similarly placed just because they are older. The Commission considers that the dispute resolution mechanism might be improved by allowing a *majority* of qualified substitute decision makers within a particular category to make a decision. Where no majority decision can be reached, the eldest person in the category would then be given the authority to make the decision. This mechanism would, in the Commission's opinion, be likely to improve the chances of making the best possible decision for the patient.

It would also seem appropriate, in the Commission's opinion, to adopt this amended mechanism for the purposes of *The Mental Health Act*.

RECOMMENDATION 11

Where more than one person is equally entitled under the Act to make a health care decision, the decision of the majority of persons so entitled shall be effective. Where no majority can be achieved, the person entitled to make the decision should be the older or eldest of the disagreeing decisions makers.* The Mental Health Act *should be amended to incorporate the same rule.

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[67] *Civil Code of Québec*, S.Q. 1991, c. 64, art. 15.

6. Scope of Authority of Substitute Decision Makers

The Commission believes that there are some decisions that substitute decision makers should not be permitted to make on behalf of incapable patients. We identified these types of decisions in our Report on *Self-Determination in Health Care* as follows:

> ... [T]here are certain non-therapeutic procedures which call for special treatment. *Inter vivos* tissue donation, medical research and non-therapeutic sterilization will rarely be contemplated by makers when delegating decision-making powers to proxies. Furthermore, such procedures will usually be of benefit to others, rather than to the maker .... A further consideration applies to non-therapeutic sterilization. The Supreme Court of Canada has ruled that a court can never give consent on behalf of an incompetent person to such a procedure, even under the court's *parens patriae* jurisdiction. It would be anomalous indeed if a proxy could do what a court could not, unless the proxy were specifically authorized by the maker.[68]

The Legislature subsequently included in *The Health Care Directives Act* a section prohibiting a proxy, in the absence of an express provision to the contrary in the directive appointing them, from consenting to medical treatment for the primary purpose of research, non-therapeutic sterilization or the removal of tissue for either transplantation or medical education or research.[69]

Substitute decision makers for personal care under *The Vulnerable Persons Living with a Mental Disability Act* are similarly fettered; in addition, they are prohibited from consenting to voluntary admission to a psychiatric facility.[70] The limitations on committees of both property and personal care appointed under *The Mental Health Act* are identical, except that they are only prohibited from consenting to medical treatment for research purposes "if the treatment offers little or no potential benefit to the person".[71]

Presumably, similar restrictions ought to be imposed on substitute decision makers who have not been directly appointed by the incapable patient. In those jurisdictions that have substitute consent legislation, similar restrictions have indeed been imposed. In Ontario, the *Health Care Consent Act* prohibits precisely the list of decisions recommended by the Commission; as well, the *Mental Health Act* prohibits substitute consent to psychosurgery.[72] The list of restrictions is more extensive in British Columbia, where substitute decision makers are not allowed to consent to any

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[68] MLRC, *supra* n. 35, at 6-7.

[69] *The Health Care Directives Act*, C.C.S.M. c. H27, s. 14.

[70] *The Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90, s. 61.

[71] *The Mental Health Act*, C.C.S.M. c. M110, s. 93.

[72] *Mental Health Act*, R.S.O. 1990, c. M.7, s. 49.

of the following procedures:[73]

- abortion (unless recommended in writing by two physicians);
- electroconvulsive therapy (unless recommended in writing by two physicians);
- psychosurgery;
- removal of tissue for either transplantation or medical research;
- experimental health care involving a foreseeable risk that is not outweighed by the expected therapeutic benefit;
- participation in medical research (unless the program has been approved by an ethics committee);
- treatment that involves using aversive stimuli to induce a change in behaviour.

Prince Edward Island does not allow substitute decision makers to consent to any of the following:[74]

- medical research, unless it is likely to be beneficial to the patient's well-being, and subject to express authority to the contrary;
- non-therapeutic sterilization;
- abortion (unless continuation of the pregnancy would be likely to immediately endanger the patient's life or health);
- electric shock used as aversive conditioning.

The Québec *Civil Code* prohibits substitute consent to care which is not "required by the state of health" (for example, cosmetic surgery or non-therapeutic sterilization) and which poses a serious risk to the health of the patient or which may cause grave and permanent effects.[75] Substitute consent to the donation of non-regenerative tissue or organs is also prohibited. No one, including the court, is permitted to give substitute consent to

- the donation of non-regenerative tissue or organs or the donation of regenerative tissue where there is a serious risk of health to the donor, or
- experimental treatment which involves serious risk to health or where the incapable person, understanding the nature and consequences of the experiment, objects.[76]

The Yukon legislation has a very short list of prohibited decisions at present (non-therapeutic sterilization), with the balance to follow by way of regulation. It also includes a unique proscription, however: a substitute decision maker (other than a guardian or a proxy) may not *refuse* consent to

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[73] *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181, s. 18(1) and B.C. Reg. 174/2003, s. 5.

[74] *Consent to Treatment and Health Care Directives Act*, S.P.E.I. 1996, c. 10, s. 12.

[75] *Civil Code of Québec*, S.Q. 1991, c. 64, art. 18.

[76] *Civil Code of Québec*, S.Q. 1991, c. 64, art. 19 and 21.

health care necessary to preserve a person's life.

> ... unless there is substantial agreement among the health care providers caring for the person that
>
> (a) the decision to refuse consent to the health care is medically appropriate; and
> (b) the substitute decision-maker has, in making the decision, complied with the duties [imposed by the Act].[77]

The United States *Uniform Act* does not contain any restrictions on the type of health care decisions a substitute can make.

Several other jurisdictions have thus seen fit to expand the categories of decisions in which substitute decision makers should not be involved. Those categories include: psychosurgery; electroconvulsive therapy; aversive conditioning; abortion (except under certain conditions); experimental health care (except under certain conditions); and withdrawal of life support (except under certain conditions). In some cases, substitutes are given more latitude than proxies under the Manitoba legislation; for example, the prohibition on consent to medical research is lifted in Prince Edward Island if the research is "likely to be beneficial to the patient's well-being."

After considering the approaches taken in other jurisdictions, the Commission does not see any reason to expand the list of decisions that a substitute is prohibited from making. The list of prohibitions that presently applies to a proxy under *The Health Care Directives Act* should also apply to other substitute decision makers. The only exception is that the Commission considers that *The Health Care Directives Act* (and *The Vulnerable Persons Living with a Mental Disability Act*) should be amended to include the same *caveat* regarding medical research that is found in *The Mental Health Act*, as there is no obvious reason why substitute decisions makers should not be allowed to consent to medical research that will be beneficial to the incapable patient.

RECOMMENDATION 12

Substitute decision makers should be subject to the same restrictions that proxies are regarding the kinds of health care to which they may consent.

RECOMMENDATION 13

The Act and* The Vulnerable Persons Living with a Mental Disability Act *should be amended to prohibit substitute consent to medical treatment for the primary purpose of research if the treatment offers little or no potential benefit to the patient.

The Commission notes an apparently unintentional inconsistency between *The Mental Health*

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[77] *Care Consent Act*, being Schedule B of the *Decision Making, Support and Protection to Adults Act*, S.Y. 2003, c. 21, s. 24.

Act, on the one hand, and *The Vulnerable Persons Living with a Mental Disability Act* and *The Health Care Directives Act*, on the other, concerning the ability of substitutes appointed under the respective Acts to *withdraw* consent to treatment once given. While it is clear that substitutes appointed under the latter two Acts are empowered to withdraw consent, as well as to give or refuse it,[78] committees appointed under *The Mental Health Act* are only empowered to give or refuse consent, not specifically to withdraw it once given.[79] The Commission considers this an obvious drafting oversight, and one which ought to be rectified.

RECOMMENDATION 14

The Mental Health Act *should be amended to clarify that committees appointed thereunder are empowered to withdraw consent to treatment.*

7. Guidelines for Substitute Decision Makers

Substitute decision makers must have some basis on which they can make the decisions they are being asked to make. Most legislation takes a "substituted" judgment approach under which substitutes must apply the patient's wishes, beliefs and values to make the decision that the patient would have made had he or she been capable. If that is impossible, the substitute must use a "best interests" test, whereby he or she determines what is in the patient's best interests.[80]

This generally describes the guidelines that apply to proxies under *The Health Care Directives Act*:

> A proxy shall act in accordance with the following principles:
>
> 1. If a directive appointing the proxy expresses the maker's health care decisions, those decisions must be complied with, subject to principle 3.
>
> 2. If the maker's decisions are not expressed in a directive, the proxy shall act in accordance with any wishes that he or she knows the maker expressed when the maker had capacity, and believes the maker would still act on if capable.
>
> 3. If the proxy knows of wishes applicable to the circumstances that the maker expressed when the maker had capacity, and believes the maker would still act on them if capable, and if the wishes are more recent than the decisions expressed in a directive, the wishes must be followed.

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[78] *The Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90, s. 57(2)(b); *The Health Care Directives Act*, C.C.S.M. c. H27, s. 1 (definition of "health care decision").

[79] *The Mental Health Act*, C.C.S.M. c. M110, ss. 63 and 90.

[80] E.I. Picard and G.B. Robertson, *Legal Liability of Doctors and Hospitals in Canada* (3rd ed., 1996) 68.

4. If the proxy has no knowledge of the maker's wishes, the proxy shall act in what the proxy believes to be the maker's best interests.[81]

There are no guidelines in that Act as to what is meant by the patient's "best interests". *The Vulnerable Persons Living with a Mental Disability Act*, however, does provide such guidelines to substitute decision makers appointed under that Act, along with a different set of guidelines relating to the patient's wishes:

> ... a substitute decision maker for personal care shall be guided by the following considerations:
>
> (a) the vulnerable person's wishes;
> (b) the vulnerable person's values and beliefs, if the substitute decision maker has no knowledge of the vulnerable person's wishes and has used reasonable diligence to ascertain whether there are such wishes;
> (c) the best interests of the vulnerable person, if
> (i) the substitute decision maker has no knowledge of the vulnerable person's wishes, values and beliefs, and has used reasonable diligence to ascertain whether there are such wishes, values or beliefs, or
> (ii) the substitute decision maker cannot follow those wishes, values or beliefs without endangering the health or safety of the vulnerable person or another person.
>
> ... A substitute decision maker ... shall consider the following factors when determining the vulnerable person's best interests ...:
>
> (a) whether the vulnerable person's condition or well-being is likely to be improved by the proposed health care;
> (b) whether the vulnerable person's condition or well-being is likely to improve without the proposed health care;
> (c) whether the benefit the vulnerable person is expected to obtain from the proposed health care outweighs the risk of harm to him or her;
> (d) whether less restrictive or less intrusive health care is a reasonable alternative to the health care proposed.[82]

A committee for both property and personal care appointed under *The Mental Health Act* (whether the Public Trustee or someone else),[83] or another person who is granted the right to make treatment decisions on behalf of another by that Act (including a proxy appointed under *The Health*

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[81] *The Health Care Directives Act*, C.C.S.M. c. H27, s. 13.

[82] *The Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90, ss. 76(1) and (2).

[83] *The Mental Health Act*, C.C.S.M. c. M110, ss. 63(4) and 96(1).

Care Directives Act)[84] must follow yet another set of guidelines:

> A person who makes treatment decisions on a patient's behalf ... shall do so
>
> (a) in accordance with the patient's wishes, if the person knows that the patient expressed such wishes when apparently mentally competent; or
> (b) in accordance with what the person believes to be the patient's best interests if
> (i) the person has no knowledge of the patient's expressed wishes, or
> (ii) following the patient's expressed wishes would endanger the physical or mental health or the safety of the patient or another person.
>
> ... In determining the patient's best interests regarding treatment, [the substitute] shall have regard to all the relevant circumstances, including the following:
>
> (a) whether the patient's condition will be or is likely to be improved by the treatment;
> (b) whether the patient's condition will deteriorate or is likely to deteriorate without the treatment;
> (c) whether the anticipated benefit from the treatment outweighs the risk of harm to the patient;
> (d) whether the treatment is the least restrictive and least intrusive treatment that meets the criteria set out in clauses (a), (b) and (c).[85]

It can be seen that there are a variety of differing guidelines in place for substitute decision makers in Manitoba, two of which *both* apply to proxies under *The Health Care Directives Act*. It does not make sense, in the Commission's opinion, to have such conflicting sets of guidelines. Legislative guidelines for substitute decision makers ought to be uniform, providing clarity and assistance to persons thrust into the role of having to make important health care decisions on behalf of another person, and to the health care providers who must assist them.

The current set of guidelines in *The Health Care Directives Act* seems to the Commission to be inadequate in that it fails to define what is meant by "best interests". Although the Commission specifically declined to include such guidance in its 1991 Report,[86] it is now persuaded that guidance would be of assistance to proxies and other substitute decision makers, provided it does not fetter their ability to take into account *all* relevant considerations. It has become clear that substitute decision makers have great difficult ascertaining, with any degree of accuracy, the decision that would be made by the patient were he or she still capable,[87] and the more assistance that can be provided the better the ultimate decision is likely to be for the incapable patient.

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[84] *The Mental Health Act*, C.C.S.M. c. M110, s. 28(1).

[85] *The Mental Health Act*, C.C.S.M. c. M110, ss. 28(4) and (5).

[86] MLRC, *supra* n. 35, at 6, 31-32.

[87] Sneiderman, *supra* n. 29, at 625.

The guidelines in *The Vulnerable Persons Living with a Mental Disability Act* are also unsatisfactory in that they place too great an emphasis on the patient's "values and beliefs", which are much too vague and ephemeral to base important health care decisions on, particularly where the substitute may have extremely limited knowledge of them. As has been pointed out by the British Columbia Law Institute:

> It may even, in certain cases, be dangerous, in light of the elusive nature of "known beliefs and values," to allow them to be the sole criterion for health care decisions that may bear upon life or death.[88]

Other jurisdictions all follow some variation on the general scheme described above, by which the substitute must base his or her decision on the patient's wishes, to the extent they are known, failing which they must base it on the patient's best interests. A number of jurisdictions insert an intermediate step, similar to that included in *The Vulnerable Persons Living with a Mental Disability Act*, which requires the substitute to base their decision on the patient's beliefs and values, if known. This is the approach that has been taken in British Columbia, Ontario and the Yukon.[89] For the reasons given above, the Commission does not believe it is sound practice to require substitute decision makers to base their decisions solely on known beliefs and values.

Newfoundland's legislation, like *The Health Care Directives Act*, makes no reference to beliefs and values and provides no guidance regarding what the patient's "best interests" are.[90] Québec's *Civil Code* only requires the substitute to take the patient's wishes into account as part of the "best interests" determination and, again, makes no reference to beliefs or values.[91]

Some jurisdictions incorporate the consideration of the patient's beliefs and values into the "best interests" determination, so that they become one factor among others to be considered in deciding what the most appropriate decision is. This was the option adopted by Prince Edward Island and in the United States *Uniform Act*,[92] and the draft United Kingdom legislation includes the patient's "wishes and feelings" as a factor in the best interests determination. It is this approach that the Commission considers best achieves the goals of proper substitute decision making.

In the Commission's opinion, the most efficacious and appropriate method of bringing clarity

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[88] British Columbia Law Institute, *Health Care Decisions and End-of-Life Issues: Terms of Reference for a Possible Project* (2002) 12.

[89] For example, *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181 (Supp.) s. 19; *Health Care Consent Act, 1996* S.O. 1996, c. 2, Sch. A, s. 21; *Care Consent Act*, being Schedule B to the *Decision Making, Support and Protection to Adults Act*, S.Y. 2003, c. 21, s. 20.

[90] *Advance Health Care Directives Act*, S.N. 1995, c. A-4.1, s. 12.

[91] *Civil Code of Québec*, S.Q. 1991, c. 64, art. 12.

[92] *Consent to Treatment and Health Care Directives Act*, S.P.E.I. 1996, c. 10, s. 13; National Conference of Commissioners on Uniform State Laws, *supra* n. 3, s. 5(f).

to this area of the law is to have a single set of guidelines applicable to all substitute decision makers, regardless of the legislation from which they derive their authority. That set of guidelines would incorporate the first three points from *The Health Care Directives Act*, followed by some guidance as to "best interests" that would allow the substitute to take into account *all* relevant considerations, but identify particular factors which he or she certainly ought to consider, including the patient's beliefs and values. The phrasing of the introduction to the "best interests"definition in *The Mental Health Act* seems to the Commission to be apt to this purpose.

RECOMMENDATION 15

Substitute decision makers, whether under the Act,* The Vulnerable Persons Living with a Mental Disability Act, *or* The Mental Health Act, *should be required to base their decisions on the following:

a) If the patient has expressed his or her wishes in a directive, those wishes must be complied with, subject to principle c).

b) If the patient's wishes are not expressed in a directive, the substitute shall act in accordance with wishes that he or she knows the patient expressed when he or she had capacity, and believes the patient would still act on, if capable.

c) If the substitute knows of wishes applicable to the circumstances that the patient expressed when he or she had capacity, and believes the patient would still act on them, if capable, and if the wishes are more recent than the decisions expressed in a directive, the wishes must be followed.

d) Subject to principles a) through c), the substitute shall act in what he or she believes to be the patient's best interests. In determining the patient's best interests, the substitute shall have regard to all the relevant circumstances, including the following:

- ***i) the patient's values and beliefs;***
- ***ii) whether the patient's condition or well-being is likely to be improved by the proposed treatment;***
- ***iii) whether the patient's condition or well-being is likely to improve or deteriorate without the proposed treatment;***
- ***iv) whether the benefit the patient is expected to obtain from the treatment outweighs the risk of harm to him or her;***
- ***v) whether less restrictive or less intrusive health care is a reasonable alternative to the treatment proposed.***

British Columbia and the Yukon both require substitutes to consult with interested persons (including the incapable patient) in order to ascertain the incapable patient's wishes, beliefs and values.[93] The Commission considers that making such an obligation explicit would provide useful guidance to substitute decision makers. Even for proxies, who have presumably been chosen because

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[93] *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181, s. 19; *Care Consent Act*, being Schedule B to the *Decision Making, Support and Protection to Adults Act*, S.Y. 2003, c. 21, ss. 18 and 19.

they have particular insight into the incapable patient's wishes, it would be helpful to have other interested persons' comments.

RECOMMENDATION 16

Substitute decision makers should be required, before making a decision, to consult (to the extent reasonable) with the patient, with any friends or relatives of the patient who ask to assist, and with any other person whom the substitute reasonably believes has relevant information, in order to ascertain the patient's wishes, beliefs and values.

8. Access to Information

Naturally, a substitute decision maker requires access to medical information about the patient, otherwise he or she cannot make an "informed" decision regarding treatment. Given the importance of the patient's right to privacy, it will be important for health care providers to know what information a substitute decision maker is entitled to receive.

The Health Care Directives Act currently provides as follows:

> Notwithstanding any restriction, statutory or otherwise, respecting the disclosure of confidential health information, but subject to any express limitation in the directive, a proxy has the right to be provided with all the information necessary to make informed health care decisions on behalf of the maker.[94]

On the face of it, this provision would certainly appear to be adequate if it were simply extended to apply to substitutes *other than* proxies. (The only note of caution might arise from the fact that, where no directive is in place appointing a proxy, the incapable patient has obviously not had an opportunity to specify limits to be placed on the information that may be released.) Similar provisions are in place in the legislation dealing with substitute decision makers in British Columbia, Newfoundland, Ontario, Prince Edward Island, Québec, Saskatchewan and the Yukon Territory.[95]

The new legislation in the Yukon sets out restrictions on the substitute's ability to use the information acquired for any other purpose and requires the substitute to keep the information secure. It does not appear that such restrictions are either necessary or desirable in Manitoba, in light of the

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[94] *The Health Care Directives Act*, C.C.S.M. c. H27, s. 18.

[95] *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181, s. 17(6); *Advance Health Care Directives Act*, S.N. 1995, c. A-4.1, s. 22; *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 22; *Consent to Treatment and Health Care Directives Act*, S.P.E.I. 1996, c. 10, s. 14; *Act Respecting Health Services and Social Services*, R.S.Q. S-4.2, s. 22; *The Health Care Directives and Substitute Health Care Decision Makers Act*, S.S. 1997, c. H-0.001, s. 19; *Care Consent Act*, being Schedule B to the *Decision Making, Support and Protection to Adults Act*, S.Y. 2003, c. 21, s. 15(1).

comprehensive provisions of *The Personal Health Information Act*.[96] The Act, in the context of protecting the privacy of individuals' health information, permits proxies and substitute decision makers to exercise all the rights of an individual with respect to that individual's health information, without restriction.[97] The Legislature has therefore already made the decision not to apply restrictions on the use of such information by proxies and substitutes.

There does, however, appear to be an omission in *The Personal Health Information Act*. The Act provides access to health care information for proxies, for committees appointed under *The Mental Health Act* (to the extent that their powers and duties permit), and for substitute decision makers for personal care appointed under *The Vulnerable Persons Living with a Mental Disability Act* (again, to the extent that their powers and duties permit); it does not, however, provide access for "nearest relatives" making substitute decisions under *The Mental Health Act*. *The Mental Health Act* itself does not give such substitute decision makers a *right* to information that would enable them to make informed decisions, but instead provides merely that the medical director of a facility *may* disclose such information to them.[98] There is thus a class of substitute decision makers whose right to information is limited which could potentially result in those substitutes having to make important health care decisions on the basis of inadequate and incomplete information – indeed, theoretically on the basis of no information at all. The Commission does not consider this a satisfactory state of affairs.

In the result, it is sufficient for purposes of statutory substitute decision makers to extend the application of the existing provisions to include them, including all substitute decision makers under *The Mental Health Act*.

RECOMMENDATION 17

The Act*, The Personal Health Information Act *and* The Mental Health Act *should be amended to provide to* all *statutory substitute decision makers the same right of access to health information that is currently provided to proxies under the first two Acts.

9. Review and Appeal Process

An important aspect of protecting patient autonomy, as the substitute decision legislation is intended to do, is providing some form of process whereby a patient (or other interested person) may obtain an impartial review of decisions made on their behalf – including a decision that they are not competent to consent. A patient under *The Mental Health Act*, for example, has the right to have a

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[96] *The Personal Health Information Act*, C.C.S.M. c. P33.5.

[97] *The Personal Health Information Act*, C.C.S.M. c. P33.5, s. 60. Needless to say, this provision renders s. 18 of *The Health Care Directives Act* entirely superfluous.

[98] *The Mental Health Act*, C.C.S.M. c. M110, s. 36(2)(d).

determination of incapacity reviewed by the Mental Health Review Board.[99] *The Vulnerable Persons Living with a Mental Disability Act* provides for hearing panels to provide recommendations to the Vulnerable Person's Commissioner, whose decisions may be appealed to the Court of Queen's Bench.[100] There does not exist any general appeal or review process, other than to the court, for other individuals who are determined by a physician to be incompetent to make treatment decisions. Nor does there exist any process by which incapable patients, or others on their behalf, may seek review of decisions made by a substitute on their behalf.

Ontario, British Columbia and the Yukon Territory have established administrative tribunals for the purpose of reviewing or hearing appeals from various decisions and determinations under their respective substitute consent legislation. The Commission considers that the availability of such review and appeal mechanisms is extremely important for the protection of incapable patients' rights. While the courts obviously have an important role as the ultimate arbiters of the law, patients should have access to more speedy, more accessible and less expensive routes of appeal. The jurisdiction, composition and mechanics of such appellate tribunals, however, are complex issues and beyond the scope of this Report.

RECOMMENDATION 18

Consideration should be given to the establishment of an administrative tribunal with the jurisdiction expeditiously to hear and determine appeals from decisions of incapacity and decisions made by substitute decision makers under all relevant legislation.

10. Protection from Liability

The current legislation provides protection from liability to proxies, and persons administering or refraining from administering treatment in accordance with the wishes expressed in a directive or a decision made by a proxy, as long as they acted in good faith.[101] In our view, this protection should be extended to include all substitute decision makers and those persons acting on their instructions.

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[99] *The Mental Health Act*, C.C.S.M. c. M110, s. 50.

[100] *The Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M. c. V90, s. 147.

[101] *The Health Care Directives Act*, C.C.S.M. c. H27, ss. 19 and 22.

RECOMMENDATION 19

No action should lie against a substitute decision maker, acting in good faith, when making a decision on behalf of a patient lacking capacity or against a health care provider, acting in good faith, on the instructions of a substitute decision maker.

11. Additional Matters

This concludes the Commission's consideration of the codification of the common law of consent and legislative provision for a default hierarchy of substitute decision makers. There are a number of ancillary matters that the Commission has not addressed, which would also have to be dealt with if the recommended legislation is enacted. For example, consideration would have to be given to such matters as whether the court should be empowered to replace a proxy who is not acting in good faith with a qualified substitute, and preventing substitute decision makers from delegating their authority. These are matters that are beyond the scope of this report, however, and the Commission makes no recommendation respecting them.

Finally, the Commission notes that, pending statutory reform, it should be possible for health care providers to minimize the problems that arise from the lack of a statutory scheme of substitute decision makers. This can be done by simply providing copies of the Health Care Directive Form suggested by *The Health Care Directives Act*[101] to all new patients on admittance to health care facilities, or on the first visit to a new physician. The form provides patients with the option of naming a substitute decision maker even if they have no desire to go further and provide specific advance health care directives. This would undoubtedly have the salutary effect of increasing the number of people who appoint their own substitute decision makers, rather than having to rely on statutory machinery selecting one on their behalf.

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[101] *The Health Care Directives Act*, C.C.S.M. c. H27, s. 11. Copies of the form are available online at <http://www.gov.mb.ca/health/documents/Health_Care_Directive.pdf> (Date accessed: 23 May 2004)

CHAPTER 7

LIST OF RECOMMENDATIONS

1. Legislation should be enacted to consolidate and standardize existing statutory provisions relating to substitute consent to health care and to address gaps in the existing legislation. (p. 20)

2. The legislation should take the form of an amendment to *The Health Care Directives Act*, with concomitant amendment of other affected legislation, and that Act should be named *The Consent to Treatment and Health Care Directives Act*. (p. 21)

3. That the Department of Health undertake a co-ordinated campaign of providing information with respect to substitute decision makers to the general public and, in particular, to patients and health care providers, similar to that instituted in the United Kingdom. (p. 23)

4. The definition of "capacity" in the Act should provide that a person may be incapable with respect to some treatments and capable with respect to others, and may be incapable with respect to a treatment at one time and capable at another. (p. 27)

5. The Act's definition of "capacity" should also apply to *The Vulnerable Persons Living with a Mental Disability Act* and *The Mental Health Act*. (p. 27)

6. When a patient is determined to be incapable with respect to a treatment decision, consent to the treatment should be sought from the highest ranked of the following persons (subject to their reasonable availability):
   a) a proxy appointed under the Act with the relevant authority;
   b) a substitute decision maker for personal care appointed under *The Vulnerable Persons Living with a Mental Disability Act* with the relevant authority;
   c) a committee of both property and personal care appointed under *The Mental Health Act*, including the Public Trustee, with the relevant authority;
   d) a spouse or common law partner, unless living separate and apart from the patient;
   e) children;
   f) parents;
   g) a person whom the health practitioner considers to be the patient's trusted friend with close knowledge of the patient's wishes;
   h) siblings;
   i) grandparents;
   j) grandchildren;
   k) uncles and aunts;

l) nephews and nieces; or
m) the Public Trustee. (p. 31)

7. The Act should be amended to permit a patient orally to designate a proxy to the health care provider responsible for their care if no valid written designation exists. If a patient designates a proxy in this manner, the health care provider should be obligated to record that designation on the patient's medical record. (p. 31)

8. A patient should not be able orally to designate as a substitute decision maker an owner, operator, or employee of a residential long-term health care facility in which he or she is resident. (pp. 31-32)

9. Persons should not be eligible to act as substitute decision makers under the Act, under *The Vulnerable Persons Living with a Mental Disability Act*, or under section 28 of *The Mental Health Act* unless they:
   a) are at least 18 years old (unless they are the parent or spouse of the person on whose behalf they are to make a decisions);
   b) are capable of consenting to the treatment proposed;
   c) are available to make a decision;
   d) are willing to assume the responsibilities imposed by the Act;
   e) have no conflict with the patient that raises a reasonable doubt whether they will comply with the duties imposed by the Act;
   f) have knowledge of the patient's circumstances; and
   g) have been in recent contact with the patient.

   Requirements a) through d) should also apply to proxies making health care decisions. (p. 34)

10. The Act should be amended to permit individuals to designate in an advance health care directive other persons, including family members, who may not act as substitute decision makers on their behalf. It should also be possible to make such a designation by orally informing the health care provider, who should be obligated to note any such designation on the individual's medical chart. (p. 35)

11. Where more than one person is equally entitled under the Act to make a health care decision, the decision of the majority of persons so entitled shall be effective. Where no majority can be achieved, the person entitled to make the decision should be the older or eldest of the disagreeing decisions makers. *The Mental Health Act* should be amended to incorporate the same rule. (p. 38)

12. Substitute decision makers should be subject to the same restrictions that proxies are regarding the kinds of health care to which they may consent. (p. 41)

13. The Act and *The Vulnerable Persons Living with a Mental Disability Act* should be amended to prohibit substitute consent to medical treatment for the primary purpose of research if the treatment offers little or no potential benefit to the patient. (p. 41)

14. *The Mental Health Act* should be amended to clarify that committees appointed thereunder are empowered to withdraw consent to treatment. (p. 42)

15. Substitute decision makers, whether under the Act, *The Vulnerable Persons Living with a Mental Disability Act*, or *The Mental Health Act*, should be required to base their decisions on the following:

    a) If the patient has expressed his or her wishes in a directive, those wishes must be complied with, subject to principle c).

    b) If the patient's wishes are not expressed in a directive, the substitute shall act in accordance with wishes that he or she knows the patient expressed when he or she had capacity, and believes the patient would still act on, if capable.

    c) If the substitute knows of wishes applicable to the circumstances that the patient expressed when he or she had capacity, and believe the patient would still act on them, if capable, and if the wishes are more recent than the decisions expressed in a directive, the wishes must be followed.

    d) Subject to principles a) through c), the substitute shall act in what he or she believes to be the patient's best interests. In determining the patient's best interests, the substitute shall have regard to all the relevant circumstances, including the following:

        i) the patient's values and beliefs;

        ii) whether the patient's condition or well-being is likely to be improved by the proposed treatment;

        iii) whether the patient's condition or well-being is likely to improve or deteriorate without the proposed treatment;

        iv) whether the benefit the patient is expected to obtain from the treatment outweighs the risk of harm to him or her;

        v) whether less restrictive or less intrusive health care is a reasonable alternative to the treatment proposed. (p. 46)

16. Substitute decision makers should be required, before making a decision, to consult (to the extent reasonable) with the patient, with any friends or relatives of the patient who ask to assist, and with any other person whom the substitute reasonably believes has relevant information, in order to ascertain the patient's wishes, beliefs and values. (p. 47)

17. The Act, *The Personal Health Information Act* and *The Mental Health Act* should be amended to provide to all statutory substitute decision makers the same right of access to health information that is currently provided to proxies under the first two Acts. (p. 48)

18. Consideration should be given to the establishment of an administrative tribunal with the

jurisdiction expeditiously to hear and determine appeals from decisions of incapacity and decisions made by substitute decision makers under all relevant legislation. (p. 49)

19. No action should lie against a substitute decision maker, acting in good faith, when making a decision on behalf of a patient lacking capacity or against a health care provider, acting in good faith, on the instructions of a substitute decision maker. (p. 50)

This is a Report pursuant to section 15 of *The Manitoba Law Reform Commission Act*, C.C.S.M. c. L95, signed this 26th day of October 2004.

Clifford H.C. Edwards, Q.C., President

John C. Irvine, Commissioner

Gerald O. Jewers, Commissioner

Kathleen C. Murphy, Commissioner

Alice R. Krueger, Commissioner

REPORT ON
SUBSTITUTE CONSENT TO HEALTH CARE

EXECUTIVE SUMMARY

A. INTRODUCTION

The Commission first noted a concern regarding substitute consent to medical treatment in its 1991 report on *Self-Determination in Health Care (Living Wills and Health Care Proxies)*, and encountered it again during its recent consideration of issues related to the withdrawing and withholding of life sustaining treatment. Accordingly, the Commission has undertaken this study of the issue to follow shortly on the publication of our final report on *Withdrawing and Withholding Life-Sustaining Treatment*, and the two reports should be considered complementary.

At common law, every person has the right to consent to, or to refuse, medical treatment. If a person is unable to give consent or refuse, for whatever reason, only a limited number of "substitutes" may do so on their behalf. If it is not an emergency, and the patient has not already appointed someone (or had someone appointed by the court) to make such decisions on their behalf, only the court (or, in some circumstances, the Public Trustee) may do so.

Existing Manitoba legislation allows competent persons over 16 years of age to appoint a substitute decision maker, but it appears that few people take advantage of this option. This fact raises serious concerns relating to the autonomy, security, and bodily integrity of patients, as well as the professional integrity and liability of professionals who have to decide from whom they will accept instructions to treat, or refuse to treat, patients who do not have a legally authorized substitute decision maker.

This report focuses on two specific issues: (a) the possibility of codifying the common law of consent to medical procedures; and (b) authorizing substitute consent to medical procedures in circumstances that existing legislation does pot address.

B. THE COMMON LAW OF CONSENT TO MEDICAL TREATMENT

Canadian common law gives a high degree of protection to an individual's personal security and bodily integrity. It is a basic principle of the common law that every person has the right to be free from unwanted interference or touching, including medical treatment, and no one may administer treatment to a person contrary to the person's wish, even where it may be necessary to preserve their life or health. This right is so fundamental that it is entrenched in the *Constitution Act, 1982*.

At common law there are four pre-requisites to a valid consent:

- it must be voluntary;
- the patient must have legal and mental capacity;
- it must be specific to both the treatment and the person administering it; and
- it must be informed.

The common law also permits treatment to be provided without a patient's consent in an emergency, where the health care provider is not aware of any contrary wish having been expressed by the patient when he or she was capable of refusing consent. Adults are presumed to be competent to grant or refuse consent, and in Manitoba this presumption has been extended by statute to apply to anyone over the age of 16. With respect to children under the age of 16, the common law has developed the "mature minor rule," which provides that a minor who has a full appreciation of the nature and consequences of medical treatment may consent to (or refuse) that medical treatment.

At common law, only a court-appointed guardian or the court itself, under its *parens patriae* jurisdiction, can consent to or refuse treatment on behalf of an incapable adult patient.

C. SUBSTITUTE CONSENT LEGISLATION

Manitoba's existing legislation sets out the parameters for substitute decision making with respect to persons with mental disorders, persons with a mental disability, and persons who have executed a health care directive. Unlike a number of other Canadian jurisdictions, Manitoba has not otherwise enacted legislation that either codifies or supplants the common law with respect to substitute decision making.

Over the last 15 years Ontario, British Columbia, Prince Edward Island, and the Yukon Territory have enacted legislation that codifies the common law of substitute consent and provides mechanisms to determine who has authority to provide substitute consent for incapable patients. Model legislation stipulating substitute consent mechanisms also exists in the United States, where a number of states have enacted either the model legislation or legislation which deals with the same subject matter. In the United Kingdom, health care providers may generally proceed with treatment without obtaining substitute consent in most circumstances, so that the need for such legislation does not exist.

D. NEED FOR REFORM AND OPTIONS FOR REFORM

The present state of the law in Manitoba is unsatisfactory, as health care providers are daily faced with situations in which the only options for obtaining a legally valid consent, or refusal of consent, to treatment are either seeking court approval or asking the court to appoint the Public Trustee as a committee of personal care and property. Neither of these options is generally practical.

as a result of which health care providers tend to rely on family members to provide substitute consent. This has implications for liability for the health care providers, and also means that people who have not prepared advance health care directives are being deprived, to some extent, of their right to self-determination.

Of the possible options for improving this undesirable situation, the Commission is persuaded that the preferred one is to enact legislation that will deal with identified gaps in the present law and standardize provisions relating to substitute consent contained within existing legislation. This could best be accomplished by amending *The Health Care Directives Act* and renaming it *The Consent to Treatment and Health Care Directives Act*.

Although there are arguments in favour of following the approach adopted by Ontario and some other jurisdictions and codifying the common law relating to substitute consent, the Commission believes that to do so would unnecessarily inhibit the evolution of the common law. Instead, the Commission recommends that the Department of Health undertake a co-ordinated campaign of providing such relevant information to patients, health care providers and others, as has been done in the United Kingdom.

The existing definition of "capacity" as it relates to consent varies from statute to statute, and it would be preferable for it to be standardized as well as clarified, as has been done in Ontario and Prince Edward Island.

The heart of any legislative substitute consent regime, of course, is a ranking of potential substitute decision makers, and the Commission recommends the adoption of a modified version of the ranking presently found in *The Mental Health Act*. The modifications would permit patients orally to designate a substitute decision maker (other than a long-term health care provider), and would also permit a trusted friend with close knowledge of the patient's wishes to provide substitute consent.

Apart from being the highest-ranked person on the statutory list, a person must meet certain criteria before they can act as a substitute decision maker. The Commission recommends that these criteria be standardized in the various Acts and that they incorporate some innovations to ensure that in every case the most appropriate possible person makes health care decisions on behalf of an incompetent patient. One such innovation would permit persons to identify other persons whom they do *not* wish to make health care decisions on their behalf.

Where disagreements arise among persons who are equally entitled to make a substitute health care decision, the Commission recommends that a decision of the majority be effective and, if no majority is possible, that the eldest person be given authority to decide.

Substitute decision makers should be under the same restrictions as to the type of treatments (or the withholding or withdrawal of treatment) to which they may consent as proxies are at present. The legislation ought also to provide guidance to substitute decision makers as to how they ought

to make their decisions. This guidance should be based on the existing guidelines in *The Health Care Directives Act*, but with explicit assistance in determining what is in the patient's "best interests". This guidance should apply equally to all substitute decision makers regardless of which legislation they are acting under. Substitute decision makers should also be required to consult with other interested persons.

The Commission also considers that the entitlement of substitute decision makers to personal health information of the patients on whose behalf they are to make decisions should be clarified.

Finally, the Commission recommends that consideration be given to the implementation of an expeditious review and appeal mechanism for patients or other interested persons who are dissatisfied with, for example, a finding of incompetence.

RAPPORT SUR LE CONSENTEMENT POUR AUTRUI À DES SOINS DE SANTÉ

RÉSUMÉ

A. INTRODUCTION

La Commission a signalé la question du consentement pour autrui à des traitements médicaux d'abord dans son rapport de 1991, intitulé *Self-Determination in Health Care (Living Wills and Health Care Proxies)* puis, à nouveau, dans son examen récent des problèmes liés au retrait ou à la restriction de traitements médicaux de survie. En conséquence, la Commission a entrepris l'étude de la question peu après la publication de notre Rapport final sur la restriction ou le retrait des traitements médicaux de survie, les deux rapports devant être considérés comme complémentaires.

En *common law*, toute personne a le droit de consentir aux traitements médicaux ou de les refuser. Si la personne ne peut pas donner son consentement ou refuser pour quelque raison que ce soit, seul un nombre limité de « subrogés » peuvent le faire en son nom. S'il ne s'agit pas d'une urgence et que le patient n'a pas déjà nommé quelqu'un (ou fait désigner quelqu'un par le tribunal) pour prendre ces décisions en son nom, seul le tribunal (ou, dans certains cas, le curateur public) peut le faire.

La loi actuelle au Manitoba permet aux personnes compétentes âgées de plus de 16 ans de désigner un subrogé, mais il semble que peu de personnes tirent profit de cette option. Il en découle des préoccupations graves en ce qui concerne l'autonomie, la sécurité et l'intégrité physique des patients, ainsi que l'intégrité professionnelle et la responsabilité des spécialistes qui doivent décider de qui ils accepteront les directives pour traiter, ou refuser de traiter, les patients qui n'ont pas un subrogé légalement autorisé.

Le présent rapport est centré sur deux questions précises : a) la possibilité de codifier la *common law* du consentement à des actes médicaux et b) l'autorisation du consentement pour autrui à des actes médicaux lorsque la loi actuelle est muette.

B. LA *COMMON LAW* DU CONSENTEMENT AUX TRAITEMENTS MÉDICAUX

La *common law* au Canada confère aux personnes un degré élevé de protection du point de vue de leur sécurité et de leur intégrité physique. Il s'agit là d'un principe fondamental de la *common law* que toute personne a le droit de ne pas être touchée ou manipulée si elle ne le veut pas, y compris par des traitements médicaux, et que personne ne peut administrer de traitement à qui que ce soit à l'encontre de la volonté de la personne, même si ce traitement peut être nécessaire pour préserver sa vie ou sa santé. Ce droit est si fondamental qu'il est enchâssé dans la *Loi constitutionnelle de 1982*.

En *common law*, il existe quatre prérequis pour établir un consentement valide :

- le consentement doit être volontaire,
- le patient doit avoir une capacité juridique et intellectuelle,
- le consentement doit être particulier et lié, tant au traitement qu'à la personne qui l'administre,
- le consentement doit être éclairé.

La *common law* permet aussi que le traitement soit donné sans le consentement du patient en cas d'urgence lorsque le fournisseur de soins de santé n'est pas informé de tout vœu contraire qui aurait été exprimé par le patient lorsqu'il était capable de refuser le consentement. Les adultes sont présumés compétents pour accorder ou refuser leur consentement et, au Manitoba, cette présomption a été étendue au moyen d'une loi pour s'appliquer à toute personne de plus de 16 ans. En ce qui concerne les enfants de moins de 16 ans, la *common law* a élaboré la « règle du mineur mûr », qui prévoit que le mineur doté d'une pleine appréciation sur la nature et les conséquences du traitement médical peut consentir à ce traitement médical, ou le refuser.

En *common law*, seul un tuteur nommé par le tribunal ou le tribunal lui-même, en vertu de sa compétence *parens patriae*, peut consentir au traitement ou le refuser au nom d'un patient adulte incapable.

C. LOI SUR LE CONSENTEMENT POUR AUTRUI

La loi actuelle du Manitoba énonce les conditions de la subrogation en ce qui concerne les personnes souffrant de troubles mentaux, celles qui ont une déficience mentale et celles qui ont exécuté une directive en matière de soins de santé. À la différence des autres ressorts canadiens, le Manitoba n'a pas, par ailleurs, adopté de loi qui codifie la *common law* ou qui la remplace en matière de subrogation.

Au cours des 15 dernières années, l'Ontario, la Colombie-Britannique, l'Île-du-Prince-Édouard, et le Territoire du Yukon ont adopté une loi qui codifie la *common law* en ce qui concerne le consentement pour autrui et prévoit des mécanismes afin de déterminer qui est compétent pour donner un consentement pour autrui au nom des patients incapables. La loi type qui prévoit des mécanismes de consentement pour autrui existe aussi aux États-Unis où un certain nombre d'États ont adopté soit la loi type, soit une loi qui traite du même sujet. Au Royaume-Uni, les fournisseurs de soins de santé peuvent généralement procéder au traitement sans obtenir le consentement pour autrui dans la plupart des cas, de sorte qu'une telle législation ne s'impose pas.

D. BESOIN DE RÉFORME ET OPTIONS OFFERTES

L'état actuel du droit au Manitoba est insatisfaisant du fait que les fournisseurs de soins de

santé se trouvent tous les jours dans des cas où les seuls choix qu'ils peuvent faire pour obtenir un consentement légalement valide ou un refus de consentement au traitement sont, soit de demander l'approbation au tribunal, soit de demander au tribunal de nommer le curateur public comme personne chargée des soins personnels et des biens. Aucune de ces options n'est, en général, assez pratique, de sorte que les fournisseurs de soins de santé tendent à s'appuyer sur les membres de la famille pour fournir un consentement pour autrui. Cette situation a des incidences sur les responsabilités des fournisseurs de soins de santé et signifie aussi que les personnes qui n'ont pas préparé des directives en matière de soins de santé à l'avance se voient privées, dans une certaine mesure, de leurs droits à l'autodétermination.

Parmi les options qui sont offertes pour améliorer ces situations indésirables, la Commission est persuadée que celle qui est à retenir consiste dans l'adoption d'une loi qui traitera des lacunes mises en évidence dans le droit actuel et normalisera les dispositions sur le consentement pour autrui de la loi actuelle. La meilleure manière d'arriver à ce résultat consisterait à modifier la *Loi sur les directives en matière de soins de santé* et à la rebaptiser *Loi sur le consentement au traitement et les directives en matière de soins de santé*.

Bien qu'il existe des arguments en faveur de l'approche adoptée par l'Ontario et par d'autres ressorts et de la codification de la *common law* en ce qui concerne le consentement pour autrui, la Commission estime que cette manière de faire empêcherait, sans que cela soit nécessaire, l'évolution de la *common law*. Autrement, la Commission recommande que le ministère de la Santé entreprenne une campagne coordonnée pour informer les patients, les fournisseurs de soins de santé et autres, de manière pertinente, à l'instar du Royaume-Uni.

La définition actuelle de la « capacité », dans la mesure où elle concerne le consentement, varie d'une loi à l'autre, et il serait préférable que cette définition soit normalisée et clarifiée comme cela a été fait en Ontario et à l'Île-du-Prince-Édouard.

Au cœur de tout régime de consentement pour autrui prévu par la loi se trouve, bien sûr, un classement hiérarchique des subrogés, et la Commission recommande l'adoption d'une version modifiée du classement actuel se trouvant dans la *Loi sur la santé mentale*. Les modifications permettraient au patient de désigner verbalement un subrogé (autre qu'un fournisseur de soins de santé à long terme) et permettraient aussi à un ami de confiance qui connaît bien les vœux du patient de fournir un consentement pour autrui.

La personne, en plus d'être celle qui est la plus haut placée dans la liste prévue par la loi, doit remplir certains critères avant de pouvoir agir comme subrogé. La Commission recommande que ces critères soient normalisés dans les différentes lois et qu'ils incluent certaines innovations pour garantir que, dans tous les cas, la personne la plus appropriée prenne des décisions de soins de santé au nom du patient ayant une incapacité. Une telle innovation permettrait aux personnes de dire qui sont les autres personnes qu'elles *ne* souhaitent *pas* voir prendre des décisions médicales en leur nom.

En cas de désaccord entre les personnes qui ont les mêmes droits pour prendre des décisions

médicales pour autrui, la Commission recommande qu'une décision de la majorité soit effective et qu'à défaut de décision majoritaire, la personne la plus âgée se voit donner l'autorité de décider.

Les subrogés devraient être soumis aux mêmes restrictions en ce qui concerne le type de traitement (ou la restriction ou le retrait de traitement) auxquels ils peuvent consentir à titre de mandataires à l'heure actuelle. La législation devrait aussi encadrer les subrogés sur la manière de prendre des décisions. Ces directives devraient suivre la *Loi sur les directives en matière de soins de santé*, mais avec une aide explicite pour déterminer ce qui est dans l' « intérêt véritable » du patient. Elles devraient s'appliquer de façon égale à tous les subrogés, quelle que soit la loi en vertu de laquelle ils agissent. Les subrogés devraient aussi être tenus de consulter d'autres personnes intéressées.

La Commission estime aussi qu'il serait nécessaire de clarifier les droits qu'ont les subrogés de recevoir l'information de santé sur les patients au nom desquels elles doivent prendre des décisions.

Enfin, la Commission recommande d'envisager de mettre en œuvre un mécanisme expéditif de révision et d'appel pour les patients ou autres intéressés qui ne sont pas satisfaits, par exemple, par une conclusion d'incapacité.